

RELIGIOUS AND NON-RELIGIOUS THERAPIST CLINICAL ENGAGEMENT AS
A FUNCTION OF SELECTED THERAPIST AND CLIENT VARIABLES

A Dissertation

by

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ABSTRACT

Religious clients represent a growing population of mental health consumers, and their problem presentations are complicated by their religious beliefs. Leading scholars assert that religious beliefs of clients are not only worthy of clinical exploration but essential for integration into treatment in order for these clients to make therapeutic gains. Yet, relative to the general population, a disproportionate number of psychologists identify as religious, a stable finding over the years and call into question of their capacity to effectively treat religious clients. Consistent with research on clinicians' value imposition, it is speculated that non-religious clinicians may demonstrate bias against religious clients. This study examined the effects of therapist religiousness (religious and non-religious), client problem presentation (religious and non-religious), and client ideation (healthy and unhealthy) on therapist clinical engagement in psychotherapy. The study employed a two-step methodology. First, an instrument was developed to measure therapist clinical engagement in psychotherapy. Second, using an analogue design, several hypotheses were tested regarding the above independent variables and therapist clinical engagement.

A national sample of psychologists (N = 154), ages 24 to 80, completed an online survey, consisting of a demographic questionnaire, and after viewing one of four video interview vignettes, also completed the Religious Commitment Inventory and the Clinical Engagement Scale. Using an established classification procedure, participants were separated into two groups: religious and non-religious. Exploratory Factor Analysis

(EFA) yielded two factors on the Clinical Engagement Scale: Case Conceptualization and Alliance/Collaboration. Analysis of variance showed main effects for client problem presentation and client ideation but no main effect for therapist religiousness on Case Conceptualization. Post hoc analysis, however, revealed an interaction of therapist religiousness and client problem presentation on Case Conceptualization. Non-religious therapists engaged more with the non-religious client than the religious client. No main effects for therapist religiousness, client problem presentation, and client ideation were found on Alliance/Collaboration. Theoretical explanations of the findings and implications for psychological treatment, training, and further research were discussed.

DEDICATION

To my husband:

Your endless support and encouragement has shown me a true picture of God's love for
me.

To my father:

You always believed in me even when I doubted myself.
Without your many sacrifices my dreams would still just be dreams.

To my mother:

I miss you every day.

To my community of friends:

Thank you for your prayers, words of encouragement, and laughter.
It takes a village.

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CHAPTER I

INTRODUCTION

Increased attention has been given to issues related to the interface between religion and spirituality in psychotherapy (Shafranske & Malony, 1990; Bergin & Jensen, 1990; Bergin, 1991; Worthington et al., 2011; McCullough, 1999; Post & Wade, 2009). The field has evolved from judging religion as separate and distinct from science, even useless at times, to considering and even validating the importance of clients' religious beliefs, attitudes, and spirituality in the context of psychotherapy (Jones, 1994). Early leaders in psychotherapy were skeptical of the psychological benefits of religion; in fact Freud and Ellis considered religiousness suggestive of psychopathology (Miller & Thorensen, 2003). Barbour (1974) agreed with early leaders by saying that "science and religion are fundamentally incompatible because science is based on facts and objectivity whereas religion is built on faith and subjective human experience". In recent years, the counseling field has developed its multicultural counseling competencies and standards (American Psychological Association, 2003) mandating psychologists to respect religious diversity. As a result, research has come forth championing the interface of religion and psychotherapy by taking a stance of acceptance and respect for the ways that religion can enhance the science and the practice of psychology. Jones asserts that, "religion, on the other hand, is not based on blind faith that is insensitive to the contours of reality, but rather is sensitive to certain realities of the human experience" (1994).

Contemporary theorists have made substantial contributions to the literature in terms of counseling culturally and religiously diverse populations (Mutter & Neves, 2010; Worthington et al., 2011; Johnson, 1992; Plante, 2007; Worthington et al., 1996; Pargament & Saunders, 2007). Over the past twenty years, research has emerged detailing the importance of utilizing religion as a partner in the process of psychotherapy including research focused on, the relationship between religion and mental health, the therapeutic alliance, psychopathology, counseling competency, and clinical training and practice. Other bodies of research have examined the efficacy of religion-accommodative psychotherapy finding evidence for the effectiveness of secular treatment modalities interfacing with religious constructs like prayer and forgiveness (Rye & Pargament, 2002; Rye et al, 2005; Beach et al, 2011; McCullough & Worthington, 1994; Baskin & Enright, 2004; Worthington et al, 2011). These advances have increased awareness of salient religious issues in the client population, provided information for practitioners seeking to discuss these issues with their clients, created an atmosphere of religious tolerance, and generated opportunity for religious clients to seek mental health treatment from secular psychotherapists.

Despite recent developments, the literature has not adequately explained the influence of both therapist and client religiousness on therapists' capacity to engage in psychotherapy with religious clients. Moreover, little is known regarding the specific behaviors mental health professionals employ to alleviate the distressing effects of their client's religious beliefs. The body of research has successfully contributed to the knowledge base regarding the ways that religion influences the theory and practice of

psychotherapy with religious clients (Knox, Catlin, Casper, & Schlosser, 2005); however, little is known about the relationship between religious or non-religious therapists and religious or non-religious clients in terms of the therapist's ability to engage in case conceptualization and alliance/collaboration. Due to this inadequacy, researchers need to examine the role religion plays in how religiousness affects clinical work, influences treatment approaches, therapeutic relationship development, and intervention selection.

Findings from several studies (Hage, 2006; Barnett & Johnson, 2011; Bishop, 1992; Kroll & Sheehan, 1989; Bergin, 1991; Larson, Lu, & Swyers, 1997; Yarhouse & Fisher, 2002; Swift, Callahan, & Vollmer, 2011; Balkin and colleagues, 2009; Flaskerud, 1986; Bilgrave & Deluty, 2002; Post, 1993) highlight concerns about the ability of therapists to effectively treat religious clients in psychotherapy. The key findings include the following factors that may influence the effectiveness of therapists: (1) the disproportion of religious therapists to religious clients (Bishop, 1992; Kroll & Sheehan, 1989); (2) the prevalence of religious clients in psychotherapy (Barnett & Johnson, 2011); (3) therapist value imposition (Bergin, 1991); (4) therapist-client matching (Swift, Callahan, & Vollmer, 2011; Balkin and colleagues, 2009; Flaskerud, 1986); and (5) American Psychological Association ethics code sensitivity to diversity mandate (APA, 2002, p. 1063).

Purpose Statement

The purpose of this study is to examine the effects of therapist religiousness, client problem presentation, and client ideation on therapist clinical engagement in

psychotherapy. Results of this investigation will contribute to the psychological literature and inform practice as it relates to religion and psychotherapy. It will also offer insight into the effectiveness of therapists working with religious clients.

Variables

The following terms are relevant to the proposed study:

1. Therapist religiousness – “the theistic and/or non-theistic beliefs, practices, and feelings that are often, but not always, expressed institutionally and denominationally as well as personally” (Magaldi-Dopman, Park-Taylor, and Ponterotto, 2011). For the purpose of this study, therapist religiousness has two levels: religious and non-religious.
2. Client problem presentation - the type of problem the client brings into therapy. For the purpose of this study this variable has two levels: religious problem and non-religious problem.
3. Client ideation - the beliefs the client holds about himself and their world that perpetuate maladaptive patterns of behavior. For the purpose of this study client ideation has two levels: healthy and unhealthy. Healthy problem ideation refers to client’s beliefs, attitudes, and thoughts about their presenting problem that are adaptive and promote therapeutic change. Unhealthy problem ideation refers to client’s beliefs, attitudes, and thoughts about their presenting problem that are maladaptive and create obstacles to therapeutic change.

4. Therapist clinical engagement - Therapist clinical engagement pertains to the capacity of a therapist to develop a clinical case conceptualization and therapeutic alliance with clients in psychotherapy.

CHAPTER II

REVIEW OF THE LITERATURE

The topic of religion and spirituality in psychological practice has been a source of contention for years and has incited caution among clinicians and scholars in terms of addressing their client's religious beliefs in the therapy context. A clearer perspective on this issue can be obtained from the extant literature. This review explores current research germane to the topic of influence of religion on therapists' engagement in psychotherapy and client problem presentation.

For approximately three decades, the literature has primarily focused on the following themes: religion and the therapeutic alliance; religion and mental health; religion-accommodative psychotherapy; therapist and client religious identity; religion and pathology; and counseling competency with spiritual issues as it relates to training and practice. However, little attention has been given to the influence of religion on therapist clinical engagement in psychotherapy as detailed by their case conceptualization as well as therapeutic alliance and collaboration

Literature for this review was located using PsychInfo, PubMed, and Google Scholar. Searches were performed using the keywords: spiritual and religion/religious, religiousness, religious orientation, and values in either the title or abstract. Results were crossed with the construct of psychotherapy using the terms counseling, therapy, and psychotherapy. Other articles were located by accessing citations of reviewed papers, conducting forward searches on relevant articles, and doing general web

searches. Web searches were appropriate for this review due to the rarity of recent scientific literature on religious and non-religious therapist clinical engagement.

This chapter will review the key literature related to: (1) the disproportion of religious therapists to religious clients (Bishop, 1992; Kroll & Sheehan, 1989); (2) the prevalence of religious clients in psychotherapy (Barnett & Johnson, 2011); (3) therapist value imposition (Bergin, 1991); and (4) therapist-client matching (Swift, Callahan, & Vollmer, 2011; Balkin and colleagues, 2009; Flaskerud, 1986)

Background

The majority of the United States are religiously affiliated, and for many clients, religion and spirituality are essential aspects of their identity, worldview, and value system (Koenig, McCullough, & Larson, 2001). According to a recent Gallup poll, 91% and 92% of Americans report a belief in God or a universal spirit and 55% say that religion is central to their daily lives (Gallup, 2011). Research from the Pew Research Center American Values study revealed that 67% of Americans report beliefs in the existence of God, the judgment of God, and the importance of prayer (Pew Forum on Religion and Public Life, 2012). Many scholars determine that given the percentage of American's reporting strong religious or spiritual beliefs, religious constructs should be integrated into the counseling process (Benjamin & Looby, 1998; Chandler, Holden, & Kolander, 1992; Hinterkopf, 1994) and acknowledged at times as a "source of support and strength" (Griffith & Griffith, 2002; Pargament, 1997; Plante, 2009).

Because the majority of American's affiliate with some form of religion, the field continues to discuss the widespread need for clinicians to include religious and spiritual

(R/S) concerns in the process of psychotherapy (Ingersoll, 1998; Mack, 1994; Pate & Bondi, 1992; Suyemoto & Macdonald, 1996). This growth of interest demonstrates the need for empirical support for the utility and efficacy of religious inclusion in psychotherapy. Scholars have stated that it is important to include religious issues in counseling research and practice because of the belief that religion affects one's thoughts, behaviors, and values (Bergin, 1988; Coughlin, 1992). Additionally, studies have shown that clients with serious mental health problems prefer spiritual or religious therapists and 81% of clients that were surveyed wished to discuss religion in therapy (Kelly, 1995). It has been noted that clients experiencing religious or spiritual problems often seek mental health services from psychotherapists, not clergy, and will often seek services from religiously affiliated psychotherapists (Barnett & Johnson, 2011). These discoveries further support the idea that non-religious therapists may not be as effective in treating religious clients.

Religious Beliefs, Practices, and Attitudes of Psychologists

From the research it is known that there are a disproportionate number of psychologists who are religious versus the total population of clients (Bishop, 1992; Kroll & Sheehan, 1989). Post and Wade (2009) found that 35% of psychologists surveyed endorsed a religious way of life compared to 72% of the population they serve. As a whole, psychologists tend to be less traditional and religious compared to the general public (Bergin, 1991). Given the deficiency of psychologists endorsing religious affiliation, it is even more surprising that only 29% of therapists surveyed rated religious content as important issues in mental health treatment (Bergin, 1991). For decades,

psychologists have viewed religion as an object, not as something in which they can partner with (Jones, 1994). This section seeks to explore what the scientific research has informed on the dynamics and contributions of religious and non-religious beliefs of mental health professionals on the practice of psychotherapy.

Religious Psychologists

The relationship between the religious beliefs of psychologists and their clinical work is important in understanding the role religion plays within the psychotherapeutic context. The worldview of psychologists speaks to how they organize their values and beliefs in both their personal and professional roles. In Jones's 1994 paper discussing the relationship between religion and the science and profession of psychology, he quoted Olthius's definition of worldview:

Worldview is a framework or set of fundamental beliefs through which we view the world and our calling and future in it...It is the integrative and interpretive framework by which order and disorder are drugged, the standard by which reality is managed or pursued. [It consist of] biophysical, emotional, rational, socio-economic, ethical, and "religious" elements. (1985, p. 155)

Jones states that a worldview is "assumed on the basis of faith; they are rarely deliberately produced through rational or empirical inquiry" (1994). Psychologists with religious worldviews are more inclined to view religion positively and see the value of religion in both their clients' lives as well as the psychotherapeutic process. A 1990 study conducted by Shafranske and Malony found that more than half of respondents currently identified with a religious affiliation. This sample of clinical psychologists

supported the inclusion of R/S issues in psychology, and more than half of respondents disclosed that their clients' religious backgrounds influence the course of treatment (Shafranske & Malony, 1990). The behaviors and attitudes of therapists towards the use of religious interventions was correlated with their views of religion rather than theoretical orientation (Shafranske & Malony, 1990). The study also found that therapists who were more sensitive to religious concerns were more optimistic about the client's progress in therapy (Shafranske & Malony, 1990). Similarly, Bilgrave and Deluty (2002) found that 72% of psychologists surveyed in their study confirmed that their religious beliefs influenced their clinical work.

Other studies have investigated the relationship between faith tradition, theoretical orientation, and worldview of religious therapists. Bilgrave and Deluty found, in their 2002 correlational study, that Christian psychologists tended to ascribe to cognitive-behavioral therapeutic orientations, eastern religions tended to predict humanistic orientations, and Jewish and non-believing psychologists tended to use psychodynamic orientations primarily. Therapists adhering to Judeo-Christian value systems report higher levels of morality, traditional gender roles, humanitarianism, and traditional family systems marked by heterosexual marriage (Balkin, Schlosser, Levitt, 2009). The religious affiliation of psychologists influences the way that they approach the science of psychology and informs their views on case conceptualization and therapeutic change through their theoretical orientation.

Religious Problem Presentation

Substantial literature exists on the relationship between religion and mental health. Some religious beliefs have even been equated with psychosis (Mohr et al., 2010). For example, the DSM-IV-TR includes V code, with religious and spiritual problem (V62.89), not to mention Axis I psychotic disorders with the presence of religious hallucinations or delusions.

Religious Clients

Much of the literature demonstrates how religious content is often prevalent in clients' psychological presentations (Barnett & Johnson, 2011). In an APA survey, 60% of member psychologists reported that clients often use religious language to discuss their concerns in therapy (Shafranske & Maloney, 1990). Religious clients will talk about their problems using language that is congruent with their religious worldview. The religious beliefs of clients may also serve as a source of strength, coping, and healthy defense against stressful life events (Bergin, Masters, & Richards, 1987; Pargament et al., 1988).

Still, clients' presenting problems and religious beliefs are not mutually exclusive domains and are often complexly interwoven perpetuating their distress and dysfunction. Kahoe (1977) found that the extrinsic oriented religious person, one who uses religion for personal gain, was more likely to adhere to authoritarian beliefs, and to lack responsibility, internal control and intrinsic motives. Models of religiousness explain the phenomena of "good" and "bad" religiousness. Allport and Ross's research (1967) on intrinsic (good) and extrinsic (bad) religiousness explains how persons use religious

beliefs in their daily lives. The “extrinsically religious person uses religion as a means of obtaining security or status” while the “intrinsically religious person internalized beliefs and lives by them regardless of social pressure” (Allport & Ross, 1967).

Because of this phenomenon, it is relevant for mental health service providers to understand how and when this occurs in their clients and to routinely assess the health of their clients’ religious beliefs (Heise & Steitz, 1991; Post & Wade, 2009). Various scholars describe situations when this might occur. For example, a fundamental religious concept in western religion is that of surrender and trust in a God or Allah (May, 1982) while healthy psychological development, in western models, promotes individual autonomy and responsibility (Katz, 1985). A client’s ultimate faith and surrender to God/Allah could be interpreted as externalization of responsibility and potentially judged as unhealthy psychological development by a non-religious therapist. Additionally, clients at times engage in dualistic thinking and judge themselves as being good or bad, right or wrong (Fukuyama & Sevig, 1997). Clients may also hold beliefs that God is judging them and fear being punished for their sins (Post & Wade, 2007). In this respect, this type of thinking can impede the client’s integration of self (Fukuyama & Sevig, 1997) perpetuating maladaptive coping mechanisms. Practitioners should be cognizant of the times when clients’ religious beliefs are either helping or hurting their psychological development (Fukuyama & Sevig, 1997) while also maintaining an awareness of their own religious biases that impact their judgments of clients’ religious beliefs.

Religious Problems

The religious problems of clients have been described by researchers, Cashwell, Bentley, and Yarborough as originating from experiencing a spiritual bypass (2007). They say that spiritual bypass “occurs when a person attempts to heal psychological wounds at the spiritual level only and avoids the important (albeit often difficult and painful) work at the other levels, including the cognitive, physical, emotional, and interpersonal” (Cashwell, Bentley, & Yarborough, 2007). Cashwell and Young explain that various psychological problems can emerge as a result of spiritual bypass including: “compulsive goodness, repression of undesirable or painful emotions, spiritual narcissism, extreme external locus of control, spiritual obsession or addiction, blind faith in charismatic leaders, abdication of personal responsibility, and social isolation” (Cashwell & Young, 2005). At times, religious clients may use their religious beliefs in dysfunctional ways that perpetuate their maladaptive coping mechanisms (Post & Wade, 2009). Bergin notes that “religion is multidimensional and some aspects of what is called religion are clearly not constructive” (1991). Some religious beliefs of clients can serve as sources of support, while others may become sources of stress. Not all religious beliefs are evidence of psychopathy; however, one cannot deny that religion and mental health factors are interwoven with clients’ presenting problems.

Religion and the Psychotherapeutic Process

Value Imposition

There is evidence from the literature that values are present and often inseparable in the psychotherapeutic process, yet research in this area has struggled to explain how

and when values ought to be integrated in the therapy context. A national survey conducted by Allen Bergin (1991) showed that mental health professionals “orient their work in terms of value judgments about the mental health implications of various behaviors and attitudes” (Bergin, 1991). He goes on to claim that “taking a values orientation also will lead to construing treatment outcomes in the broader sense of modification of a life-style rather than the usual immediate and narrow criterion of symptom relief” (1991). Both client and therapist orient their lives towards a set of values that influence their engagement in therapy.

The multicultural literature has been keenly interested in the phenomena of therapist bias and published several studies describing the features of values imposition (Atkinson, 1985; Usher, 1989). Studies have shown that clinicians perceive themselves as more multiculturally competent when they share similar a cultural background with their client. Another study by Balkin and colleagues (2009) reinforces the idea that when a counselor’s religious identity was conforming to others who held similar beliefs, the counselor reported higher levels of multicultural knowledge. In this respect, research has shown that counselors from different ethnic or racial groups as their clients tend to assign more severe diagnosis (Loring & Powell, 1988). The literature suggests that clinicians judge improvement in therapy on the basis of moving towards their own religious beliefs.

Furthermore, therapists may unintentionally impose their values and beliefs on clients through their choices of treatment protocols. The set of values that therapists orient their lives around can unintentionally influence their selection of treatment goals

and intervention strategies (Bergin, 1991). How counselors perceive their own values compared to their clients can unintentionally influence their reactions, perceptions of their clients as well. In terms of religious values, the research has also indicated that the religious orientation of therapists affects their attitudes and perceptions (Shafranske, 1990; Bergin, 1991). For example, highly religious people tend to perceive themselves as more moral compared to nonreligious people (Hunter, 2001). Additionally, individuals who tend to support traditional gender roles and are “more rigid and authoritarian in religious identity tended to exhibit more homophobic attitudes (Lease & Schulman, 2003; Peek et al., 1991; Rosik, Griffith, & Cruz, 2007; Balkin, Schlosser, & Levitt, 2009). The values of a therapist may also positively influence their attitudes and perceptions. Perkins found that “religious commitment was related to increased humanitarian ideals and decreased prejudice (1992).” Additionally, Laythe and colleagues found that when aggression-submission is controlled for, religious fundamentalism was negatively correlated with racism (2002). Because the values of therapists influence their personhood and worldview, thus influencing their clinical work, Bergin concludes that “it is essential to be explicit about this valuation process” so that the “client will be able to elect responses to the value choices underlying the goals and procedures of treatment (1991).

Therapist Matching

Psychotherapy outcome literature has been interested in the specific and non-specific factors responsible for therapeutic change in clients for decades. Therapist *matching to* has been found to be an effective method of facilitating therapeutic change

by adapting therapy to the needs, interests, and styles of clients. Swift and colleagues discovered in their 2011 study that “accommodating patient preferences modestly enhances treatment outcomes and decreased premature termination.” Balkin and colleagues (2009) hypothesized that religious therapists may be more effective in treating religious clients as a result of certain value laden issues and the therapists’ ability to communicate using language relevant to the client’s culture (e.g., Flaskerud, 1986). Overall, individuals seem to value a counselor who is sensitive to their spiritual concerns and willing to express mutual respect for differences in religious beliefs.

Religion-Accommodative Psychotherapy

As research on matching client to treatment increases, there has been a rise in outcome studies examining the effectiveness of religious therapies adapted from secular therapies such as Christian-cognitive behavioral therapy and Christian Rational Emotive Therapy as well as an increase in studies looking at the influence of R/S variables like forgiveness (Propst et al., 1992; Rosmarin, et al., 2010; McCullough & Worthington, 1994; Worthington et al., 2011; Baskin & Enright, 2004). Much of the outcome research over the past two decades has aimed to inform the therapist as to what treatments will work for specific populations of clients. With religion-accommodative psychotherapy increasing in popularity in the literature, practitioners are seeing more clients wishing to integrate their religious beliefs into their treatment. Several review papers, by Smith and colleagues (2007), found that R/S therapies performed better than alternate treatments. Hook and colleagues found that R/S performed better than control groups but equal to secular treatments. Worthington and colleagues research (2011) show that there is some

evidence to support that R/S therapies perform better than secular therapies, but studies vary in design rigor. R/S therapies when compared to their same secular therapy do not perform better on psychological variables but do on spiritual variables (Worthington et al., 2011).

There are three different levels of studies reviewed in this section. The first are studies with no control group, second, studies with control groups, and third, studies with alternate therapy that use a dismantling design. In this section, research on religion-accommodative psychotherapy can be divided into two treatment formats: interventions tested on groups and interventions tested on individuals. Overall, groups respond positively to R/S accommodated interventions while studies using individuals reveal inconclusive results.

Of the six group studies reviewed, the effectiveness of R/S focused interventions including the construct of forgiveness in treating anxiety, depression, eating concerns, substance use, and psychological distress variables were examined. Rye and Pargament conducted a study with level 2 grade of evidence, which examined the effects of a religious treatment integrating forgiveness among college women who had been wounded by a romantic relationship. Their study found no difference between secular and religious treatment compared to the control group; however, both groups improved faster than the group receiving no treatment (Rye & Pargament, 2002). Richards and colleagues investigated the eating attitudes and self-esteem of 122 female participants in an inpatient eating disorder program. The study compared a spirituality group with a standard emotional support group. Patients in the spiritual intervention group scored

lower on psychological disturbances and improved at faster rates at the end of treatment compared to other groups in the program (Richards, Berrett, & Hardman, 2006).

Furthermore, other group studies found positive results indicating reduction in anxiety and PTSD symptomatology, suicidality, and substance use when treatment included R/S components compared to control groups (Margolin, Avants, & Arnold, 2005; Breitbart et al., 2010; Harris et al., 2011).

Individual intervention studies examined the effectiveness of religious accommodated psychotherapy like pastoral care, religious-sociocultural psychotherapy, forgiveness interventions, and a prayer focused relationship enhancement program, on reducing anxiety, depression, stress, and promoting relationship satisfaction. In terms of relationship enhancement outcomes, religiousness of treatment does not significantly impact treatment effects of facilitating forgiveness and decreasing depression among divorced individuals (Rye, et al., 2005). On the other hand, Beach concluded that his prayer focused relationship enhancement program had significant effects for marital outcomes. Individual studies in this area had substantial sample sizes with good statistical power.

Studies investigating effectiveness in treating anxiety and depression among individuals reported mixed results. Razali and colleagues found in a study of anxiety disorder and major depressive disorder patients with strong religious and cultural backgrounds that symptoms reduced at greater frequency than those patients not receiving additional religious-sociocultural interventions, but differences became null at the end of 6 months (1998). Results indicate positive outcomes initially, but treatment

effects were not maintained at follow-up. Rosmarin's preliminary study with anxious individuals in a religious Jewish community found initial support for the efficacy of spiritually influenced therapy (electronic delivery) in reducing symptoms of anxiety. Results indicated that SIT delivered significant reduction in anxiety symptoms like stress, worry, depression, and uncertainty among the sample population (Rosmarin et al., 2010). Additional studies also found positive results in the effectiveness of religious psychotherapy in reducing depression and anxiety in religious patients (Propst et al., 1992 & Azhar et al., 1994).

Conversely, Bay and colleagues found no difference in anxiety and depression scores of 166 patients in the hospital recovering from a coronary artery bypass graft surgery who received chaplain visits compared to control group (2008). In the same study, positive religious coping increased in treatment group and decreased in control group indicating positive results in religious dimension of patients' recovery (Bay et al. 2008).

Pecheur and Edwards in a 1984 study found no difference between religious and secular religious cognitive therapy in reducing depression among Christian clients. Hawkins and colleagues in 1999 examined the effects of Christian cognitive-behavioral therapy on clinically depressed Christian adults in an inpatient treatment facility. Results of the study again show there is no significant difference between Christian cognitive-behavioral therapy (CBT) and secular CBT, but, overall, participants reported improvement in their mood and functioning (Hawkins et al., 1999). The study also found that as spiritual well-being improved in CCBT there was a greater improvement in

depression scores (Hawkins et al., 1999). While results appear inconclusive as to the efficacy of religious accommodative psychotherapy, results point to the clinical benefits of including religious content in psychotherapy.

Ethical Considerations

The American Psychological Association (2003) mandates psychologists to respect religious diversity because of its role in the functioning of many religious clients. Therapists run the risk of avoiding religious content in clients' psychological presentations because of a lack of familiarity with religion, a discomfort with religious issues, or a lack of training in how to approach religious content with religious clients. Nevertheless, the Ethical Principles of Psychologists and Code of Conduct urges clinicians to respond sensitively to clients of diverse backgrounds (American Psychological Association, 2002). The following codes, from three professional organizations, should guide the efforts of mental health providers who work with religiously diverse populations. Principle E of the APA Ethics Code, Respect for People's Rights and Dignity, states that "psychologists are aware of and respect cultural, individual, and role differences, including those based on...religion, and consider these factors when working with members of such groups" (APA, 2002, p. 1063). Standard 2.01b further asserts that among maintaining respect for people's religious beliefs, psychologists "obtain training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals" as it pertains to the client's religion (APA, 2002, p. 1064). If sensitivity to a client's religious beliefs

is neglected, the result could lead to “underutilization of service, misdiagnosis, iatrogenic treatments (APA, 2000, 2003; Ridley et al., 2001; Trimble & Fisher, 2006).

The American Counseling Association’s Code of Ethics (ACA Code of Ethics; ACA, 2005) emphasizes that “counselors recognize that culture affects the manner in which clients’ problems are defined” (E.5.b. Cultural Sensitivity). Finally, The American Association for Marriage and Family Therapy Code of Ethics (AAMFT Code of Ethics; AAMFT, 2001) asserts that “marriage and family therapists respect the rights of those persons seeking their assistance, and make reasonable efforts to ensure that their services are used appropriately” and “provide professional assistance to persons without discrimination on the basis of... religion” (AAMFT Code of Ethics; AAMFT, 2001, para. 8).

In conclusion, each ethics code described above directs psychotherapists to respect client’s religious beliefs and/or expression of religion, alleviate any detrimental effects of the therapist’s religious biases, and consider each client’s relevant religious beliefs when conceptualizing and implementing treatment plans (Barnett & Johnson, 2011). Several authors affirm the ethical importance of targeting a client’s religious impasse when the psychotherapist judges it to have causal relationship to the client’s distress (Johnson, Ridley, & Nielsen, 2000). In line with each of these ethics codes, it can both harmful to ignore the religious problem and/or attack the client’s religious beliefs, neither of which is the message of these codes.

CHAPTER III

METHODS

This chapter is divided into the following sections: the study procedures, the study participants, the measures, the study design, and a description of the data analysis that will be used to answer research questions.

Procedure

A power analysis was conducted using GPower 3.1 to determine the number of participants needed to provide the study with a reasonable chance of obtaining clinical significance between the groups. Results of a power analysis indicated that a total of 128 subjects, divided between religious and non-religious therapists for each cell (8 groups), would be needed to test the study's main hypotheses. The sample size is based on a power level of .80 for a fixed effects, factorial ANOVA.

Participant Recruitment

Upon approval of the study by the Institutional Review Board at Texas A&M University, the researcher recruited participants from a membership database of the American Psychological Association (APA). Solicitation for the online survey was made through the electronic mailing lists for Division 17 and 12 of the APA, local psychology-related graduate programs, and from agencies, clinics, and private practices in the College Station area. All recruiting methods provided details of informed consent, as well as procedures for keeping participant identities anonymous. Participants were told that in exchange for their anonymous, voluntary participation in the study, they

would have a chance to enter a random drawing for one of two \$50 Amazon gift certificates. Participants were told that participation was voluntary, and there would be no penalties for denying participation.

In order to be considered for participation, potential recruits must have earned a doctoral degree in a psychology-related field and completed at least one year of clinical experience. Participants were emailed detailed instructions as well as a link to an Internet-based, self-administered, survey questionnaire through Qualtrics. E-mail reminders were sent approximately 7 days after the initial correspondence. In addition, a second reminder was sent approximately 7 days after initial mailing to non-respondents. Participants were asked to fill out a brief demographics questionnaire along with the RCI-10. Prior to being presented with the stimulus question asking them to rate their level of clinical engagement, participants were asked to view a 3-minute videotaped portion of a scripted intake session depicting a woman who presents with either a religious problem with healthy ideation, a religious problem with unhealthy ideation, a non-religious problem with healthy ideation, or a non-religious problem with unhealthy ideation. After viewing their vignettes, participants were asked to consider themselves in the role of the therapist and were asked to answer questions regarding how they would work with the client in the vignette. Data collection lasted approximately 14 weeks.

The Survey Instrument

A core vignette was created and then modifications were made to represent the four cells of the 2 (religious problem, non-religious problem) by 2 (healthy ideation, unhealthy ideation) by 2 (religious therapist, non-religious therapist) design. Figures 1

and 2 presents the cell structure. The case vignettes, located in Appendix A, combined two of the study's independent variables depicting four different client scenarios. Within each of the four case vignettes, the stories varied in terms of client psychological presentation (religious problem versus non-religious problem) and client ideation (healthy versus unhealthy). Individuals with knowledge of psychotherapy were asked to assess the realism and clarity of the vignettes through an established rating system before data collection began. Raters were practicing psychologists from a local university counseling center. The five raters were a mix of male and female with ages ranging from thirty to sixty, and no rater had previous experience with the vignette in this study. Intra-class correlation was selected because of its utility in measuring reliability among multiple raters (Fagot, 1991). Inter-rater reliability estimate indicated strong agreement between raters ($ICC = .944$).

Figure 1. Cell Structure according to Religious Therapist

		Client Problem Presentation	
		Religious	Non-religious
Client Ideation	Healthy	Religious Problem with Healthy Ideation N = 16	Non-religious Problem with Healthy Ideation N = 20
	Unhealthy	Religious Problem with Unhealthy Ideation N = 28	Non-religious Problem with Unhealthy Ideation N = 16

Figure 2. Cell Structure according to Non-religious Therapist

		Client Problem Presentation	
		Religious	Non-religious
Client Ideation	Healthy	Religious Problem with Healthy Ideation N = 19	Non-religious Problem with Healthy Ideation N = 23
	Unhealthy	Religious Problem with Unhealthy Ideation N = 16	Non-religious Problem with Unhealthy Ideation N = 16

Development of the Video Intake Sessions

From the written vignette, a script was created which included both client and therapist roles. The therapist's statements illustrated basic open-ended questions like, "Tell me a little bit about yourself" and "How do you think counseling can help you?" The actor playing the therapist was also encouraged to utilize appropriate non-verbals so as to emulate an actual therapy session. The full script is located in Appendix B. Next, the script was segmented into four parts and displayed on a computer monitor positioned on a desk in front of the actor playing the client. The session was recorded using a webcam that was positioned atop the computer monitor. The actor playing the role of the therapist was positioned in front of and just to the left of the monitor. From the perspective of the viewer, the client and therapist were face-to-face where the viewer sees the back of the therapist's head and the face of the client. The videotaped vignette was conducted in a university counseling center. The actor portraying the client was a 29 year-old Caucasian female. Her presenting problem revolved around a combination of mostly situational factors. These included mood disruption and marital distress. The vignette also included relevant background information pertaining to the client's family system, marriage difficulty, interpersonal functioning, and religious beliefs. The researcher opted for a videotaped session because it was believed that, when compared to the written case vignette, the session better contextualized the experimental task of conceptualizing the therapeutic process.

Coding

For each participant questionnaire collected, the data was entered into an SPSS 22 data file. Each questionnaire was coded for each of the three independent variables.

Religiousness was coded as religious (0) and non-religious (1). Problem Type was coded as religious (0) and non-religious (1). Client Ideation was coded as unhealthy (0) and healthy (1). Participant clinical engagement scores, gender, and degree type, and field of study information were entered into the data file. Gender was coded as male (1), female (2), transgender (3), and other (4). Degree type was coded as PhD (1), PsyD (2), and EdD (3). Lastly, field of study was coded as Counseling Psychology (1), Clinical Psychology (2), School Psychology (3), and Other (4). A histogram was created for gender, degree type, and field of study to assure that these variables were evenly distributed throughout the sample. In addition, these three variables were assessed for equal distribution throughout each of the eight groups with frequency distributions.

Participants

A sample size of 234 participants was obtained. Participants were recruited through the electronic mailing lists for Division 17 and 12 of the American Psychological Association (APA), local psychology-related graduate programs, and from local agencies, clinics, and private practices. Of the 234 participants that attempted the survey, approximately 36% (n=80) did not complete the surveys, yielding 64% participant completion. Of the 154 completed surveys, less than 5% of cases (n=2) had missing data. Procedures for handling missing data are addressed in Chapter 4.

Participants were largely female (52.6%), with 46.8% identifying as male and 0.6% identified as other. Participant ages ranged from 27 to 80 ($M = 48.94$; $SD = 14.17$). Participants were largely White (79.9%), followed by African American (5.8%), Hispanic or Latino (5.2%), Multiracial (4.5%), and Asian American (4.5%).

Participants largely represented counseling psychology (56.5%), clinical psychology (39.6%), and school psychology (2.6%). Approximately 1.3 percent of participants reported working in some other field of study including theology. The largest percentage of participants reported having attained Doctor of Philosophy degrees (95.5%), followed by Doctor of Psychology degrees (3.2%), and less than one percent reported earning Doctor of Education degrees. Participants having greater than 20 years of work experience in a psychology related field represented the largest group (41.6%), followed by 1 to 5 years (17.5%), 5 to 10 years (16.2%), 10 to 15 years (13.0%), and 15 to 20 years (11.7%). Participant demographic descriptive statistics of field of study and type of degree is broken down by religiousness and presented in Table 1.

Table 1 Demographic Descriptive statistics by Therapist Religiousness

Variable	Religious		Non-religious	
	N = 88	%	N = 66	%
Field of Study				
Counseling Psychology	52	59	35	53
Clinical Psychology	30	34	31	47
School Psychology	4	4.5	0	0
Other	2	2.3	0	0
Degree Type				
PhD	84	95	64	97
PsyD	3	3.4	2	3
EdD	1	1.1	0	0

Participants were largely Christian (71%), followed by other traditions (6%), Judaism (5%), Unitarian (3%), Islam (1%), Latter Day Saints (1%), Buddhism (1%), and 5% preferring not to answer. Out of 101 participants who self-identified as religious, 22 people did not specify which religious tradition they followed. Table 2 provides gender, age, race/ethnicity, field of study, and type of degree of the sample. The percentages reported below do not add up to 100 due to incomplete surveys.

Table 2 Participant Demographics

Demographic Variable	N	%
Gender		
Male	72	46.8
Female	81	52.6
Other	1	>1
Age		
18 – 30	16	10.4
31 – 40	28	18.2
41 – 50	24	15.6
51 -60	25	16.2
≥ 61	38	24.7
Race/Ethnicity		
White	123	79.9
African American	9	5.8
Hispanic or Latino	8	5.2
Multiracial	7	4.5
Asian American	7	4.5
Field of Study		
Counseling	87	56.5
Clinical	61	39.6
School	4	2.6
Other	2	1.3
Degree Type		
PhD	147	95.5
PsyD	5	3.2
EdD	1	>1

Measures

Demographic Questionnaire

Participants completed a brief demographic questionnaire before viewing the videotaped vignette and answering survey questions. Participants indicated their age, gender, race, state of residence, field of study (e.g. Counseling Psychology, Clinical Psychology, School Psychology, or other degree (e.g. PhD, PsyD, or EdD) and years of counseling experience (e.g. 5-10 years, 1-5 years, 10-15 years, 15-20 years, and 20+ years). The demographic questionnaire is provided in Appendix C.

Religious Commitment Inventory-10

Religiousness was measured using the Religious Commitment Inventory-10 (RCI-10) (Worthington et al., 2012). The RCI-10 is identified as the primary measure of religiousness out of many instruments found in the literature because: it was developed by scholars with expertise in religion/spirituality (Worthington et al., 2003), has been utilized in previous research by other notable scholars, and has demonstrated sound reliability and validity across heterogeneous samples. This instrument was developed to assess religious commitment in individuals across a variety of faith traditions. The measure consists of ten, five-point scale, Likert-type items that assess the degree to which the participant agrees with statements concerning religious beliefs and practice.

The RCI-10 has shown good reliability and validity. Worthington et al. reported good internal consistency ($\alpha = .93$) and 3-week test-retest reliability ($r = .87$) for the RCI-10. Previous studies established high convergent validity with other measures of religious commitment (mean correlation = .64, range .58 to .70). Worthington et al.

(2012) have also demonstrated that the RCI-10 consists of two subscales. The first subscale or contains six items that measure intrapersonal religious commitment and the second consists of four items that measure interpersonal religious commitment.

Clinical Engagement Scale

A thorough review of the literature on clinical case conceptualization and therapeutic alliance was conducted. This review revealed no current instruments that combines the measurement of a therapists' capacity to develop both a case conceptualization as well as a therapeutic alliance with their clients.

Item development. Items were developed by considering existing scales that assess therapeutic alliance and case conceptualization, including the Working Alliance Inventory (Appendix F; Horvath & Greenberg, 1989). These items were de-identified as to their parent scale and were evaluated with the assistance of my faculty advisor, Dr. Ridley. After evaluating the larger group of items, Dr. Ridley and I revised and supplemented the remaining items relevant to this study with new items. Because I conceptualized the scale in terms of tasks present within the context of psychotherapy, that include the development of case conceptualizations, intervention strategies, therapeutic alliance, as well as confrontation constructs, the initial group of 12 items was developed to represent those tasks between therapist and client.

Based on the above conceptualization, a 5-point Likert-type scale was developed to evaluate a therapists' level of clinical engagement. The decision to include questions targeting conceptualization, intervention strategies, ability to confront, as well as ability

to develop a therapeutic alliance was based in part on the researcher's understanding of the therapeutic process within psychotherapy.

The items targeted four dimensions of therapist clinical engagement in psychotherapy. The first set of items targeted therapists' perceived ability to establish a therapeutic alliance with the client. The second set of items targeted therapists' perceived ability to conceptualize the client's problem presentation. The third set of items targeted therapists' perceived ability to utilize targeted and appropriate intervention strategies. The fourth set of items targeted therapists' perceived ability to use therapeutic confrontation.

Design

This study utilized an experimental analogue design. This study seeks to approximate the therapeutic situation in order to control for confounding variables (Heppner, Wampold, & Kivlighan, 2008). Analogue designs enhance internal validity, but may limit generalizability to actual counseling situations (Heppner, Wampold, & Kivlighan, 2008). The independent variables are therapist religiousness (religious/nonreligious), client problem presentation (religious problem/nonreligious problem), and client ideation (healthy/unhealthy). The dependent variable (therapist clinical engagement) will be measured in relation to combinations of the independent variables. The subjects were block assigned to one of the 4 groups resulting in approximately 32 participants per group to ensure equal participation across the cells. Cell assignment was determined from participants' full-scale score on the RCI-10. A cut-off score of 21 was used to assign participants. Based on Worthington's study

(2003), means for secular groups on the full-scale RCI are between 21 and 26 (SDs between 10 and 12). Worthington suggests using the most extreme scores within the range; therefore, for the purpose of this study, participant scores less than or equal to 21 were assigned to the non-religious group.

Data Analysis

Multiple univariate analyses of variance (ANOVA) were used to analyze the data collected in this study in order to account for potential inter-correlations among response measures in identifying significant effects of independent variables on a combination of response measures. This design was used because there are multiple independent variables that affect the dependent variables, yet the dependent variables are independent of each other. The dependent variables for this study were Case Conceptualization and Alliance/Collaboration of the Clinical Engagement Scale.

CHAPTER IV

RESULTS

Chapter 4 discusses the results of the statistical analyses conducted to answer the research questions and sub-questions. The research questions asked whether therapist religiousness, client problem presentation, and client problem ideation were sources of effect on therapist clinical engagement. This section of the dissertation describes the analyses conducted and the results obtained in order to answer these questions.

Statistical Package for the Social Sciences (SPSS) 22 was used to conduct a series of Analysis of Variance (ANOVA) tests in order to obtain the information needed to answer the research questions. Before conducting these data analyses, basic statistical descriptions, such as means, standard deviations, and range scores, about demographic information were conducted. Also, model assumptions for each analysis were checked.

Research Questions

The research questions and corresponding null and alternative hypotheses for the dissertation study are listed below.

Research Question 1: Does religious content of problem presentation (religious content or no religious content) affect therapist clinical engagement?

H₀1: There is no difference in therapist clinical engagement between religious and non-religious therapists with clients who present with religious content.

H₁1: There is a difference in therapist clinical engagement between religious and non-religious therapists with clients who present with religious content.

Research Question 2: Does religiousness of therapist (religious or non-religious) affect therapist clinical engagement?

H₀₂: There is no difference in therapist clinical engagement based on religiousness of therapist (religious or non-religious).

H₁₂: There is a difference in therapist clinical engagement based on religiousness of therapist (religious or non-religious).

Research Question 3: Does problem ideation (healthy or unhealthy) affect therapist clinical engagement?

H₀₃: There is no difference in therapist clinical engagement with client's who exhibit healthy problem ideation compared to those who exhibit unhealthy problem ideation.

H₁₃: There is a difference in therapist clinical engagement with clients who exhibit healthy problem ideation compared to those who exhibit unhealthy problem ideation.

Data Considerations

Data was screened for accuracy and model assumptions through several methods. After data was entered into SPSS, frequency statistics and box plots were used in order to identify extreme values. In this study, less than 5% of the cases used in the final analysis contained missing data (n=2). These cases were replaced by using the series mean. Series mean is a method for replacing missing data by taking the mean of all available cases for the specific variable and replacing missing cases with the mean.

An exploratory data analysis was conducted to determine if the therapist clinical engagement score distributions were normally distributed. Univariate normality was assessed through examination of the data for skewness and kurtosis. Skewness is a measure of the symmetry of the distribution, while kurtosis indicates the flatness or peakedness of the distribution. Histograms, as shown in Figure 3 and Figure 4, displayed moderate, negatively skewed distributions for both dependent variables (Case Conceptualization and Alliance/Collaboration). To decrease skewness, power transformations were performed in order to normalize data by reflecting and taking the square root of the variable. See Figures 5 through 7. Multivariate normality was assessed by first computing a Mahalanobis Distance for each case and then data was screened again using Kolmogorov-Smirnov tests of normality. Once data transformations were performed, Levene's test of homogeneity of variance was employed and confirmed that the variances in Therapist Clinical Engagement scores for Case Conceptualization and Alliance/Collaboration were statistically equivalent ($F_1=1.43, p = .197$; $F_2=1.314, p = .247$). Table 3 provides statistics related to skewness and kurtosis following data transformations for the study variables.

Figure 3. Histogram of Therapist Clinical Engagement Scores in Case Conceptualization before data transformation

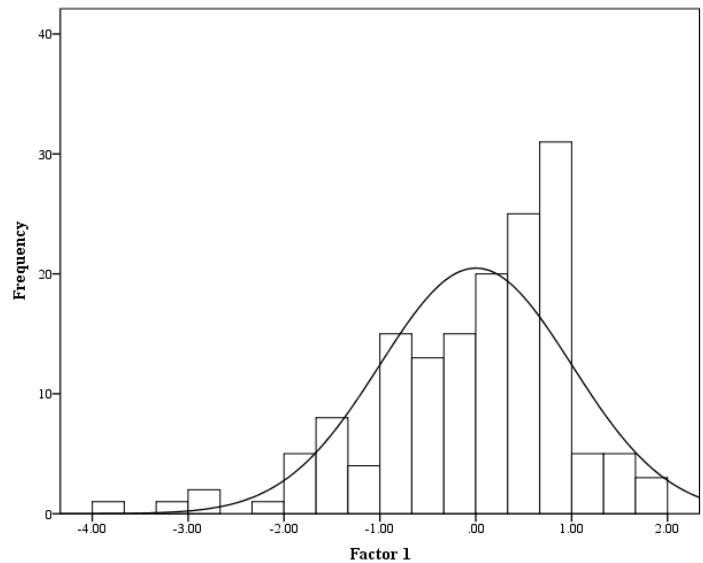


Figure 4. Histogram of Therapist Clinical Engagement Scores in Alliance/Collaboration before data transformation

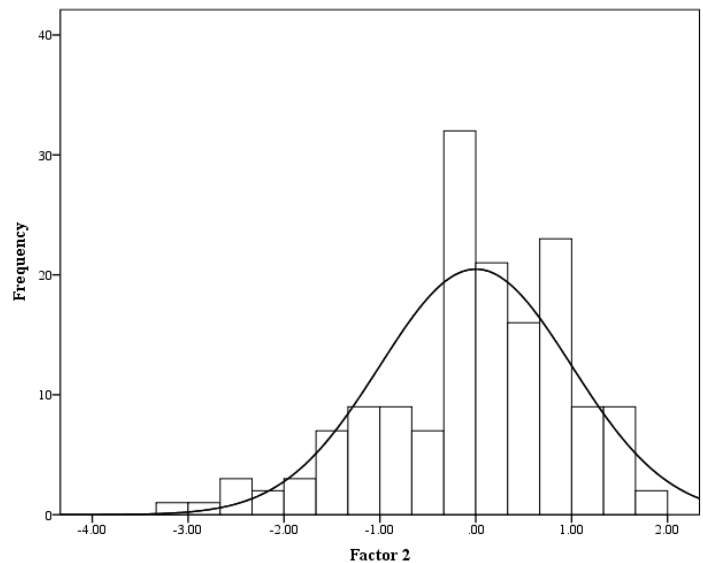


Figure 5. Histogram of Therapist Clinical Engagement Scores in Case Conceptualization after data transformation

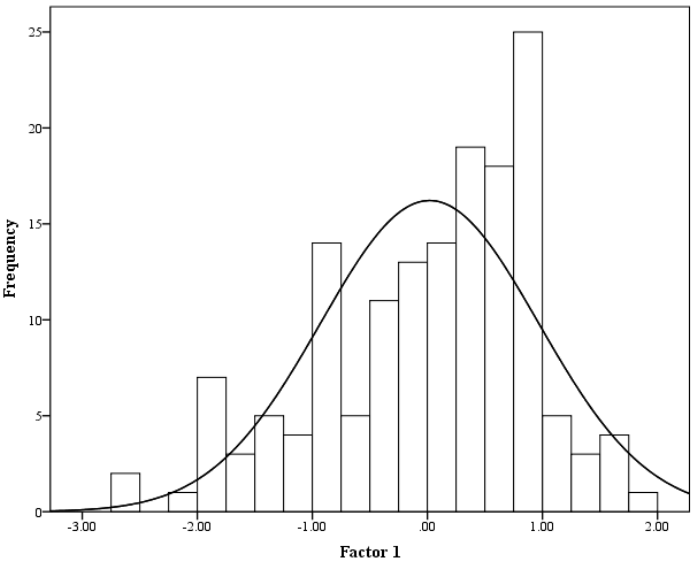


Figure 6. Histogram of Therapist Clinical Engagement Scores in Case Conceptualization after Mahalanobis Distance

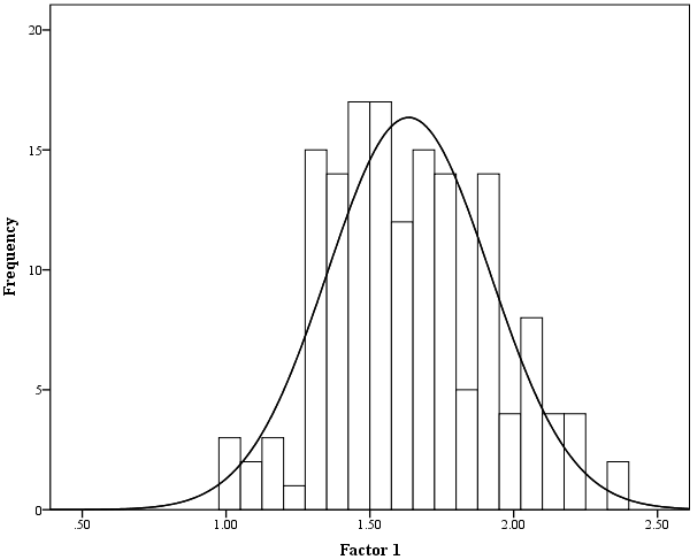


Figure 7. Histogram of Therapist Clinical Engagement Scores in Alliance/Collaboration after data transformation

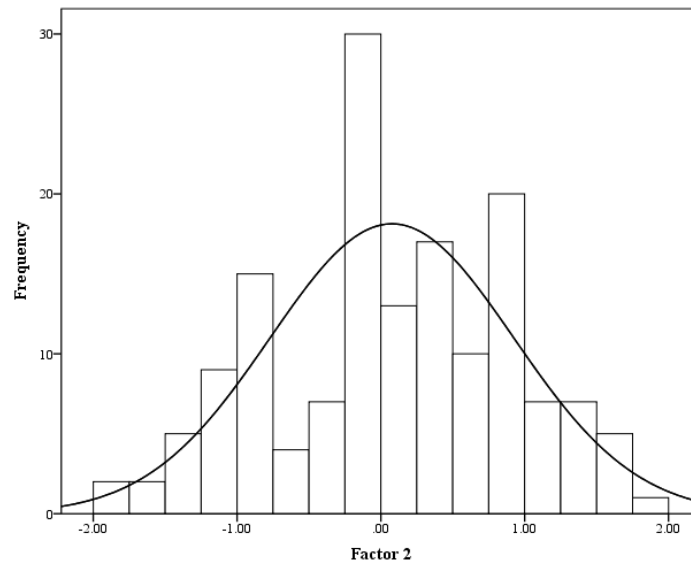


Table 3 Means, Standard Deviations, Skewness, and Kurtosis for Dependent Variables (Case Conceptualization and Alliance/Collaboration)

Variable	Mean	SD	Skew	Kurt
Case Conceptualization	1.635	0.282	0.262	-0.309
Alliance/Collaboration	0.077	0.847	-0.170	-0.652

Clinical Engagement

The purpose of this section describes the results from the initial validation testing as well as factor analysis of the Clinical Engagement Scale (CES), a self-report measure that examines a therapist's conceptualization and alliance building capabilities.

Internal Consistency

Preliminary reliability estimates of internal consistency for the Clinical Engagement Scale was examined using Chronbach's alpha test. Internal consistency reliability analysis was chosen because of its popularity in research and utility in examining homogeneity between the items in a measure (Kazdin, 2003; Furr & Bacharach, 2008). The CES shows good internal consistency of 0.877.

Exploratory Factor Analysis

Factor analysis was used to determine the number of factors in the Clinical Engagement Scale, the associations between those factors, and which items belong to which factors (Furr & Bacharach, 2008). In this study, the researcher used Statistical Package for the Social Sciences (SPSS) 22 to conduct Exploratory Factor Analysis (EFA), specifically the principal components analysis, to explore new modeling options while adhering to the original construct definitions. Exploratory factor analysis provided evidence of factorial validity for the CES. One-hundred and fifty-four participants were included in the analysis. Exploratory factor analysis, with Varimax rotation, produced a two-factor scale representing a case conceptualization component and an alliance/collaboration component to therapist clinical engagement. The initial eigenvalues showed that the first factor explained 43% of the variance and the second factor 16% of the variance. Table 4 presents the factor loadings, eigenvalues, and percent of variance explained as well as the rotation solution used.

All 6 items on Case Conceptualization presented a loading of 0.40 or higher. Items included: "Can you accurately conceptualize the client's problem presentation," loaded at 0.837; "Can you connect the consequences of the inconsistencies in the client's feelings, beliefs, and attitudes with the client's dysfunctional behavior," loaded at 0.790; and "Can you challenge the client to become consistent in their feelings, beliefs, and attitudes," loaded at 0.625. The Case Conceptualization factor reported a Cronbach's alpha at 0.885. Case Conceptualization accounted for 33.02% of the total variance in the CES instrument.

All 6 items on Alliance/Collaboration presented a loading of 0.40 or higher. Items included: "Can you establish a therapeutic alliance with the client," loaded at 0.742; "Are you motivated to help the client change," loaded at 0.702; and "Can you collaborate with the client to set suitable treatment goals," loaded at 0.689. The Alliance/Collaboration factor reported a Cronbach's alpha at 0.821. Alliance/Collaboration accounted for 26.72% of the total variance in the CES instrument.

Table 4 Summary of Exploratory Factor Analysis Results for 12 items from the Clinical Engagement Using Principal Component Analysis with Varimax rotation and Parallel Analysis (N = 154)

Item	Factor Loadings	
	Factor 1 Case Conceptualization Component	Factor 2 Alliance/Collaboration Component
Can you accurately conceptualize the client's problem presentation?	.837	.160
Can you establish interventions appropriate to the client's problem presentation?	.765	.296
Can you establish a therapeutic alliance with the client?	.364	.742
Can you connect the consequences of the inconsistencies in the client's feelings, beliefs, and attitudes with the client's dysfunctional behavior?	.790	.151
Are you motivated to help the client change?	.119	.702
Can you empathize with the client?	.025	.793
Can you be impartial in your conceptualization of the client's problem presentation?	.061	.622
Can you help the client achieve positive therapeutic outcomes?	.307	.669
Can you comprehensively conceptualize the client's problem presentation?	.838	.100
Can you clarify inconsistencies in the client's feelings, beliefs, attitudes, and behaviors?	.808	.109
Can you challenge the client to become consistent in their feelings, beliefs, and attitudes?	.625	.259
Can you collaborate with the client to set suitable treatment goals?	.252	.689
Eigenvalues	3.96	3.20
% of variance	33.02	26.72

Note: Factor loadings over .40 appear in bold.

Data Analysis

Based on factor analysis and resultant two-factor structure of the CES, the researcher elected to utilize each factor as two distinct dependent variables (Case Conceptualization and Alliance/Collaboration) in all statistical analysis in order to examine the effect of the three factors for each dependent variable separately. Multiple univariate analyses of variance (ANOVA) were used to analyze the data collected in this study in order to account for potential inter-correlations among response measures in identifying significant effects of independent variables on a combination of response measures. Eta squared (η^2) was used to measure the percentage of variability in therapist clinical engagement scores that could be accounted for by the independent variables. This design was used because there are multiple independent variables that affect the dependent variables, yet the dependent variables are uncorrelated with each other. The dependent variables for this study were Case Conceptualization and Alliance/Collaboration of the Clinical Engagement Scale.

First, a factorial ANOVA was conducted to evaluate the effects of therapist religiousness (religious/non-religious), client problem presentation (religious/non-religious problem), and client ideation (healthy/unhealthy) on therapist clinical engagement in Case Conceptualization. The mean score on the Case Conceptualization component of the Clinical Engagement Scale was 30.12 ($M=31.12$, $SD=6.16$). For the Alliance/Collaboration component, the mean was 34.90 ($M=34.90$, $SD=4.56$).

The means and standard error statistics for Case Conceptualization and Alliance/Collaboration as a function of the three independent variables are presented in

Table 5. Table 6 presents means and standard deviation statistics for Case Conceptualization and Alliance/Collaboration as a function of Therapist Religiousness. For further analysis of significant effects, multiple comparison procedures were performed on significant interactions to identify significant differences among conditions.

Table 5 Means and Standard Error Statistics

Variable	Case Conceptualization		Alliance/Collaboration	
	M	SE	M	SE
Client Problem Presentation				
Religious				
Non-religious	.196	.111	-.030	.117
	-.204	.110	-.039	.006
Client Ideation				
Healthy	-.253	.107	.154	.121
Unhealthy	.246	.115	-.223	.113
Therapist Religiousness				
Religious	.052	.103	.028	.108
Non-Religious	-.060	.119	-.097	.126

Note: Means taken from factor scores

Table 6 Means and Standard Deviations for Dependent Variables

Variable	Religious Therapist		Non-religious Therapist	
	M	SD	M	SD
Case Conceptualization	30.79	5.65	29.20	6.72
Alliance/Collaboration	35.13	4.22	34.66	4.92

Note: Means taken from cumulative scores

Group Differences

The factorial ANOVA was conducted to investigate group differences on Case Conceptualization in client problem presentation, client ideation, and, therapist religiousness among participants. ANOVA results, presented in Table 7, show a significant main effect for client problem presentation, [$F(1, 147) = 8.59, p = .004$, partial $\eta^2 = .055$] and client ideation [$F(1, 147) = 9.83, p = .002$, partial $\eta^2 = .063$] on therapist clinical engagement. Participants showed significantly more clinical engagement in Case Conceptualization when the client presented with a non-religious problem compared to the client who presented with a religious problem. Participants showed significantly more clinical engagement in Case Conceptualization when the client exhibited unhealthy ideation compared to healthy ideation. However, the effect sizes were small, ($\eta^2 = .055$; $\eta^2 = .063$) (Muijs, 2011). This means that 5.5% of the between subjects variance is accounted for by problem presentation and 6.3% of the between subjects variance is accounted for client ideation. The main effect for religiousness of therapist was not significant, $F(1, 147) = .345, p = .558$, partial $\eta^2 = .002$. Participants' religiousness did not influence therapist clinical engagement scores in Case Conceptualization.

An interaction was found between client problem presentation and therapist religiousness, $F(1, 147) = 7.506, p = .007$, partial $\eta^2 = .049$. However, the effect size is small, ($\eta^2 = .049$) (Muijs, 2011). This means that 4.9% of the between subjects variance is accounted for by the interaction of problem presentation and therapist religiousness. Gabriel's post hoc pairwise comparison test was used to test the interaction. This

method was selected because it explicitly allows for unequal sample sizes (Kirk, 1995). Post hoc test results are presented in Table 8. The tested interaction revealed that non-religious participants showed more clinical engagement on Case Conceptualization when presented with a client who had a non-religious problem.

Table 7 Factorial Analysis of Variance for Therapist Clinical Engagement, Case Conceptualization Component

Source	<i>Df</i>	<i>F</i>	η^2	<i>p</i>
Client Problem Presentation	1	8.59	.055	.004
Client Ideation	1	9.833	.063	.002
Therapist Religiousness	1	.345	.002	.558
Problem x Client Ideation	1	.846	.006	.359
Client Ideation x Religiousness	1	.049	.000	.825
Problem x Religiousness	1	7.506	.049	.007
Error	147			

* $p < .05$

Table 8 Multiple Gabriel Comparisons for Interaction of Client Problem Presentation and Therapist Religiousness on Therapist Clinical Engagement (Case Conceptualization)

Sample Comparison		Population Mean Difference			
Problem Presentation- Therapist Religiousness Interaction (I – J)		Differences Between Sample Means	95% Confidence Interval		
I	J		<i>p</i>	Lower Bound	Upper Bound
Condition 1:	2	.1522	.121	-.0247	.3292
Non-religious problem x	3	.2414	.006*	.0521	.4307
Non-religious therapist	4	.1922	.017*	.0242	.3603
Condition 2:	1	-.1522	.121	-.3292	.0247
Non-religious problem x	3	.0891	.608	-.0968	.2751
Religious therapist	4	.0400	.924	-.1243	.2043
Condition 3:	1	-.2414	.006*	-.4307	-.0521
Religious problem x	2	-.0891	.608	-.2751	.0968
Non-religious therapist	4	-.0491	.893	-.2266	.1284
Condition 4:	1	-.1922	.017*	-.3603	-.0242
Religious problem x	2	-.0400	.924	-.2043	.1243
Religious therapist	3	.0491	.893	-.1284	.2266

* $p < .05$

The factorial analysis of variance was conducted to investigate group differences on Alliance/Collaboration in client problem presentation, client ideation, and therapist religiousness among participants. ANOVA results are presented in Table 9. Results indicated no difference between client problem presentation [$F(1, 147) = .140, p = .709$, partial $\eta^2 = .001$], client ideation [$F(1, 147) = 3.754, p = .055$, partial $\eta^2 = .025$], and therapist religiousness [$F(1, 147) = .015, p = .901$, partial $\eta^2 < .001$] on therapist clinical engagement. Client problem presentation, client ideation, and therapist religiousness did not influence therapist clinical engagement scores on Alliance/Collaboration.

Table 9 Factorial Analysis of Variance for Therapist Clinical Engagement, Alliance/Collaboration Component

Source	<i>Df</i>	<i>F</i>	η^2	<i>p</i>
Client Problem Presentation	1	.140	.001	.709
Client Ideation	1	3.754	.025	.055
Therapist Religiousness	1	.015	.000	.901
Problem x Client Ideation	1	2.619	.018	.108
Client Ideation x Religiousness	1	.043	.000	.836
Problem x Religiousness	1	.089	.001	.766
Error	147			

* $p < .05$

CHAPTER V

DISCUSSION

This chapter is divided into the following sections: a summary of the findings, interpretation of the findings, limitations of the study, and implications and directions for future research.

Brief Summary of Findings

For the present study, therapist engagement in both religious and non-religious client scenarios was measured using the Clinical Engagement Scale, wherein self-reported levels of case conceptualization and alliance/collaboration tasks were targeted. The results of the study demonstrated differential support of the research hypotheses in that therapists' engagement in case conceptualization related to client problem presentation and client ideation. Therapists' religiousness did not have a main effect on their engagement in case conceptualization. However, an interaction was obtained in that non-religious therapists were more engaged in the case conceptualization of the non-religious client than the religious client. In addition, therapists' engagement in alliance/collaboration was not related to their religiousness, client problem presentation, or client ideation. Effect size was measured using eta squared. Accordingly, problem presentation and client ideation revealed small effect sizes ($\eta^2 = .055$; $\eta^2 = .063$) and the interaction of problem presentation and therapist religiousness revealed a small effect size ($\eta^2 = .049$) (Muijs, 2011).

Exploratory Factor Analysis

The Clinical Engagement Scale (CES) showed evidence of a two-factor structure for an adult population of psychologists. The items on the measure loaded into categories labeled Case Conceptualization and Alliance/Collaboration. The factor loadings were stronger on the case conceptualization subscale than on the alliance/collaboration subscale. These findings suggest that clinical engagement is a more complex phenomenon than originally conceptualized, and this complexity has to be taken into account in attempting to understand its interplay with other variables in clinical research.

Factor Number 1: Case Conceptualization

Six items that loaded under this factor are characterized by a set of clinical activities in which clinicians engage to understand their clients. Through this type of engagement therapists integrate information about clients and their presenting problems into useful framing in order to facilitate the process of therapy. According to Sperry (2012), “case conceptualization is a method and process of summarizing seemingly diverse clinical information about a client into a brief, coherent statement or ‘map,’ which elucidates the client’s basic pattern and which serves to guide the treatment process” (p. 354). Case conceptualization is integral to counseling and psychotherapy (Ridley & Jeffrey, in preparation). According to these authors, clinicians have to form clinical portraits of clients in order to better understand them and select appropriate interventions. Without a sound conceptualization of clients, clinicians are likely to be misdirected in how they approach treatment.

Factor Number 2: Alliance/Collaboration

Six items that loaded under this factor are characterized by a set of relational activities that both clinician and client engage in throughout the process of therapy. Both parties work with each other to develop and agree upon treatment goals, facilitate the change process, and develop a therapeutic relationship (Bordin, 1980; Horvath & Greenberg, 1989; WAI-T; Horvath, 1984; Luborsky, 1976; Marmar, Weiss, & Gaston, 1989; Marziali, 1984; Strupp & Hadley, 1979). Effective therapy requires the establishment of a relationship that enables the client to trust the therapist, for it is within that relational context that therapeutic gains are made. Research findings demonstrate that the therapeutic relationship contributes to client improvement (Lambert & Barley, 2001). Furthermore, the impact of clinician techniques and interventions is diminished without a strong therapeutic relationship.

Interpretation of Findings

Case Conceptualization

There was a main effect for the problem presentation on case conceptualization. Therapists showed more engagement in case conceptualization when the client presented with a non-religious problem than when the client presented with a religious problem. There was no main effect for the religiousness of therapists on engagement in case conceptualization. However, an interaction of therapist religiousness and client problem presentation was found. Non-religious therapists demonstrated more engagement with the client who did not have religious content in her problem presentation than the client who had religious content in the problem presentation.

Several possibilities exist for this current finding. First, non-religious therapists' discomfort or lack of familiarity with religion may serve as a barrier for them to engage in the conceptualization of religious problem presentations. Their non-engagement may be a classic example of avoidance behavior, the consequences of which nevertheless may prevent clients from making therapeutic gains. Furthermore, as there is a disproportionate number of religious therapists compared to the population of clients (Bishop, 1992; Kroll & Sheehan, 1989), only a smaller subgroup (29%) view religion as worthy of clinical exploration (Bergin, 1991).

Second, graduate programs in psychology are deficient in their training related to the treatment of clients who present with religious issues (Hage, 2006). Since case conceptualization is the way that therapists integrate information about clients and their presenting problems and respond to client needs and goals throughout the process of therapy, non-religious therapists may be less equipped to apply their conceptualization skills to clients with religious problems. Even with training mandates on diversity and multiculturalism, less attention is given to religion than other topics such as race, ethnicity, socio-economic status, gender, and sexual orientation. Although their research is somewhat dated, Yarhouse and Fisher (2002) found that clinical psychology training programs have yet to formally establish such training requirements (Yarhouse & Fisher, 2002).

Another possible explanation is the lack of a model for case conceptualization that provides a framework for clinicians to organize and synthesize the religious beliefs of clients in a way that explains their maladaptive patterns of behavior. Worthington

(1988) proposed a model for understanding the values of religious clients and their impact on the counseling process. Park and Slattery (2009) also wrote about their approach to case conceptualization that includes R/S issues. However, neither approach seeks to achieve a comprehensive case conceptualization that explains how the religious beliefs of clients may be maladaptive and hinder therapeutic change. A model was proposed to address religion in clinical supervision to better equip students than didactic training methods (Aten and Hernandez, 2004). The Aten and Hernandez model consists of eight domains that target the following areas: intervention skills, assessment, individual and cultural differences, interpersonal assessment, theoretical orientation, problem conceptualization, treatment plans, and professional ethics (Aten & Hernandez, 2004). These domains provide useful information for supervisors helping their supervisees more competently incorporate their clients' religious beliefs into the counseling work. However, a missing component in the training is the conceptualization and change facilitation when the religious beliefs of clients, though valid and at times supportive, hinder their growth and negatively impact their psychological health and wellbeing.

Fourth, therapist value imposition may influence non-religious therapists (Bergin, 1991; Post, 1993). They may be less able to conceptualize religious problem presentations because of differences in worldview, values, and biases about religion. Previous research (Swift, Callahan, & Vollmer, 2011; Balkin and colleagues, 2009; Flaskerud, 1986) showed evidence of the effectiveness of matching therapist to client as a method to facilitate therapeutic change. Contributing factors to the effectiveness of

this method where the ability of the therapist to accommodate client preferences, having the ability to communicate and understand one another while using shared language or vocabulary, and having a mutual understanding and respect for value-laden issues. The differences in worldview between therapist and client may impede the ability of a clinician to accurately and comprehensively develop case conceptualizations based on shared values and beliefs.

Both client and therapist orient their lives towards a set of values influencing their theoretical orientation, as well as their treatment of and perceptions of clients (Bergin, 1991; Bilgrave & Deluty, 2002). First, therapists from different religious beliefs may unintentionally impose their values on clients simply from the way they approach case conceptualization based on their own theoretical framework. Bilgrave and Deluty noted in their 2002 study on the religious beliefs and theoretical orientation of psychologists that certain religions predicted their adherence to certain psychotherapeutic approaches. Their study found that psychologists from eastern religions, like Hinduism and Buddhism, tended to ascribe to humanistic orientations, whereas Jewish and atheist psychologists tended to use psychodynamic orientations (Bilgrave & Deluty, 2002). These findings do not necessarily predict poor treatment outcomes when humanistic therapists work with Christian clients; however, the potential for unintentionally disengaging from their clients increases. Similar results apply to cognitive behavioral therapists. This approach to case conceptualization may unintentionally invalidate a Hindu client who values the practice of meditation and connection to the transcendence. Second, the beliefs of therapists about their morality

could negatively impact the way they interact with their clients. Bergin's 1991 study showed that mental health professionals "orient their work in terms of value judgments about the mental health implications of various behaviors and attitudes" (Bergin, 1991). Since values influence treatment strategies, a therapist might be more engaged if the client shares similar values because the therapist can remain within the comfort of similar worldviews.

Finally, therapist bias, although unavoidable, affects the counseling process. The bias of non-religious therapists, toward client problem presentations that are non-religious in nature and away from client problem presentations that are religious in nature, goes against the APA's ethics on diversity (APA, 2002, p. 1063). The American Psychological Association directs psychotherapists to respect the religious beliefs of clients, alleviate any detrimental effects of the therapist's religious biases, and consider each client's relevant religious beliefs when conceptualizing and implementing treatment plans (Barnett & Johnson, 2001). Post (1993) was also concerned with the risk therapists run when their own religious bias inhibits the counseling process in his statement:

No one could deny that an incorrect clinical interpretation of a religious patient would be harmful if it leads to an incorrect or distorted picture of a persons' mental health. Certainly, a bias against religion would contribute to failing to recognize the religious patient in her or his fullest human dimension – a failure that can only compromise the therapeutic enterprise. It is difficult to estimate the extent of this bias in clinical practice, but to the extent that it may occur, it is cause for concern (p. 370).

When religious content is disregarded or ignored from clients' presenting problems, client welfare is jeopardized.

In contrast to non-religious clients, religious therapists did not demonstrate any difference in engagement of case conceptualization between the client who presented with religious content and the client who did not present with religious content. Several characteristics of the study sample may have contributed to this finding. First, in terms of participant values, research shows that "religious commitment was related to increased humanitarian ideals and decreased prejudice" (Perkins, 1992). According to Merriam-Webster dictionary online, humanitarian is defined as "a person who works to make other people's lives better" and marked by characteristics of acceptance and kindness (Merriam-Webster's online dictionary, n.d.). It is possible that religious therapists held similar values that guided their answers to questions of case conceptualization for both religious and non-religious clients. A study by Laythe and colleagues (2002) found that when aggression-submission is controlled for, religious fundamentalism was negatively correlated with racism. There is evidence to support that religious therapists may not be differentially engaged in case conceptualization because they are tolerant and accepting of client diversity.

Second, religious therapists may have a higher comfort level with client psychological presentations that consists of non-religious content than non-religious therapists have with client psychological presentations that consists of religious content. The difference between the two groups of therapists might represent classical approach-avoidance, precipitated by the presence or absence of threat. Many religious therapists

undoubtedly spend more time treating clients who do not present specifically with religious content. In addition, their professional training and experience typically occurs in contexts that do not have a religious affiliation. Therefore, their persistent exposure to non-religiousness on multiple levels may extinguish any anxieties they have.

Conversely, exploring religious content with religious clients could be threatening to non-religious therapists. They have a limited frame of reference, and their clinical training probably was inadequate to help them feel confident in conceptualizing cases that include religious content. What if they misinterpret the religious content? What if they overestimate or underestimate clients' psychopathology due to their limited understanding of religion? What if they mistakenly offend the client because of their misunderstanding or inappropriate use of religious language. Similar to Ridley's (2005) perspective on unintentional racism, non-religious therapists may avoid conceptualizing religious content in an effort to remain unbiased. In the process, however, they may inadvertently undermine psychotherapy due to their failure to create a sound "clinical picture" of the client, which further leads to an inappropriate intervention.

Finally, participants in this study were mostly Christian (71%) and while the participants were mismatched to the client in terms of religion, religious therapists may have been equally engaged because of having shared western ideals. Specifically, the vignette portrayed a female client who was presumably married to one man, although not referenced explicitly. Additionally, western culture tends to value heterosexuality and monogamy, as well as the pursuit of individual happiness. Although the client in the vignette did not specify which religious tradition she followed there was evidence that

she attended church and held a belief in God, which is congruent with a Christian belief system. Because religious therapists have a comfort level with religion they are not threatened by religious content in clients' presenting problems.

There was a main effect for client ideation. Therapists showed more engagement in case conceptualization when the client presented with unhealthy ideation than when the client presented with healthy ideation. It is possible that therapists are more engaged in case conceptualization when they judge the client's problem ideation as unhealthy. Perhaps case conceptualization takes less effort on the part of the therapist to engage the client in the change process if the client internalizes the correct proportion of the responsibility for their presenting problem and for therapeutic change. Clients who have unhealthy ideation have beliefs about their problem that hinder therapeutic change. Unhealthy ideation may increase the complexity of the client's presenting problem, which may force the therapist to increase their level of clinical engagement in order to develop a more comprehensive case conceptualization.

Alliance/Collaboration

There was no difference between religious and non-religious therapists on alliance/collaboration. One possible explanation is that field-based training throughout graduate school places a higher emphasis on relational aspects of therapy (e.g. microskills) than cognitive tasks in therapy (i.e. case conceptualization). Field-based training programs devote more time in training on developing a therapeutic alliance than on the cognitive aspect of conceptualizing clients. Training is aimed at teaching and developing the utilization of microskills as opposed to other cognitive tasks like

assessment and diagnosis. Counseling microskills, such as paraphrasing and using open-ended questions, aid the therapist in their ability to attend to the client's non-verbals as well as the content of what they are saying. As a result, collaboration becomes more of a relational task than a cognitive task and clinicians do not allow their religious beliefs to impede alliance and collaboration. Therefore, even though non-religious therapists do not engage in case conceptualization with religious clients, they are equally engaged in the alliance and collaboration with religious clients as religious therapists.

Another possibility for the current findings pertains to the sample of participants. The majority of participants reported that they had worked in a psychology related field for over twenty years. Because of the wealth of clinical experience, veteran psychologists represent a consistent ability to engage in relational tasks regardless of differences between them and the client in the area of religion.

There was no difference on alliance/collaboration due to client ideation. It is possible that at intake the therapists' attention is aimed towards building rapport and developing a working relationship rather than case conceptualization. Perhaps the therapist exhibits more engagement with alliance/collaboration in the beginning stages of the therapeutic work and once an alliance is established, the attention of the therapist shifts to considering how the client's thoughts, attitudes, and beliefs about his problem are incorporated into the case conceptualization.

There was no difference on alliance/collaboration due to client problem presentation. Similarly, to the previous finding, it is possible that at intake the therapist is focused on rapport building and relating to the client on a human level as opposed to

case conceptualization. Perhaps the therapist exhibits more engagement on alliance in the beginning stages of the therapeutic work and later on the therapist considers the content of the client's presenting problem and formulates a posteriori case conceptualization that includes information surrounding the client's presenting problem that was gathered during intake.

Implications of Findings

This study provides valuable information about the influence of therapist religiousness, client problem presentation, and client ideation on therapist clinical engagement in psychotherapy. Specifically finding that non-religious therapists are less engaged in case conceptualization tasks when the client presents with religious content in their problem presentation, and the ability of therapists to engage in alliance/collaboration tasks was not influenced by the religiousness of the therapist, nor client problem presentation, or client ideation. As opportunities for mental health services increase, bringing more religious individuals to the offices of secular providers, and as long as the American Psychology Association continues to validate the importance of interfacing psychology with religion when necessary, it is important for researchers and practitioners alike to gain a clearer and fuller understanding of the impact on service delivery and counseling efficacy.

Theory Explication

Findings suggest that the field must move beyond the matching paradigm which questions whether or not therapists and clients should be matched based on their religiousness. There is a need for more in-depth explanation of how and why clinicians

relate to clients on the basis of their religiousness or non-religiousness and clients' religiousness or non-religiousness. The matching paradigm is an oversimplification of the complexity and the nuisances of the counseling interaction.

Clinical Practice

Model. A working model for conceptualizing religious problem presentations is needed so that therapists, regardless of their religiousness, are equipped to formulate accurate and comprehensive case conceptualizations that integrate clients' religious beliefs into the problem definition, treatment goals, and intervention strategies. The key is the development of a process that meaningfully integrates client religiousness into therapy and has utility for religious and nonreligious therapists.

Assessment. For clinicians working with religious clients, it would be beneficial to conduct a thorough assessment of religious commitment. Measures such as the RCI-10 can aid in clinicians' understanding of their clients' worldviews since highly religious individuals are more likely to view their world through the lens of their religious beliefs (Worthington et al., 1996). Understanding a client's worldview and the degree to which their religious beliefs influence their worldview can help clinicians better integrate religious and spiritual dimensions into their treatment.

Confrontation of unhealthy religious beliefs. The field must move beyond its current perspective on multicultural counseling competence from undisputed and passive acceptance to critical, yet respectful, examination of clients' religious beliefs. Not all beliefs of clients based on their interpretations of religion are healthy. A similar dynamic exists with respect to clients' culturally-based beliefs and values. Ridley, Ethington, and

Heppner (2008) pointed out how an uncritical acceptance of clients' beliefs and values can impede therapeutic change. They argued that “counselors need to be aware of how the cultural values of their clients manifest themselves as part of the change process” (pg. 379). Similarly, the findings argue for counselors to be aware of the manifestation of clients’ religious beliefs. Specifically, counselors must first be able to identify when the religious beliefs of clients are the underlying causes of their self-defeating behaviors, and second, challenge the clients to increase their consciousness of the ways those beliefs contribute to their current distress and mental health statues (Ridley, Ethington, & Heppner, 2008).

Training

Graduate training programs may benefit from incorporating several additions to their training of counseling skills and multicultural counseling. Specifically, training programs might be able to help students address client’s religious beliefs by engaging trainees, first, at the personal level. First, if through safe and non-judgmental dialogues, students were allowed to discuss their biases, the impact their biases have on the counseling process, and respectfully confront those biases, they might be better equipped to engage in similar dialogues with their clients regarding religiousness. Second, if trainees were exposed to religiously diverse populations through either in-class seminars or through their practicum sites, trainees may feel more comfortable engaging with clients with diverse religious beliefs. Thirds, if students were given practical skills, ways to talk about religion with clients, they might feel empowered to incorporate their clients’ religious beliefs into the treatment plans without worry of misinterpreting or

offending the client. Finally, if students were trained to identify when a clients' religious beliefs were either serving or supporting the client and when their beliefs were functioning to keep them stuck in dysfunctional behavioral patterns, they might feel confident to confront the client's religious beliefs and help them move toward healthy psychological functioning.

Future Research

The current study provides further evidence for the necessity of counseling process research examining the influence of therapist religiousness, client ideation, and client problem presentation on therapist clinical engagement on which future research can expand. Research that explores broader constructs related to therapist clinical engagement, such as conceptualizing religious presenting problems and developing a therapeutic alliance with religiously diverse populations, would help illuminate the relationship dynamics and psychotherapeutic processes between therapist and religious client. Conducting qualitative research through methods such as interviews or focus groups could aid in understanding therapists' individual experiences with religious clients and how their own religious beliefs or biases impact case conceptualization and alliance building. These methods may provide information that could help interpret the quantitative findings from the present study. Additionally, further research is needed to understand the mechanism by which religious problem presentations relate to lower levels of therapist clinical engagement.

Limitations of the Current Study

Results of the present study should be evaluated with the consideration of its limitations. The first limitation is consistent with that of analogue designs. One disadvantage of analogue research is the issue of generalizability. While analog studies offer the best possibility for maximizing control of variables (Heppner, Wampold, & Kivlighan, 2008), they are removed from the authentic counseling process, which diminishes the generalizability of results. Additionally, the analog design may not have provoked realistic feelings and responses present within an actual therapy encounter. Many of the participants who completed the study are veteran psychologists and may not represent the views of early career psychologists that may be more familiar with the new APA standards of care as well as multicultural counseling competency benchmarks. Also, most of the participants in the “religious” category were Christian. Therefore, extrapolating these results to the perceptions of representatives from other faith traditions should be done with caution.

Moreover, participants may have taken the study from a variety of settings such as public work spaces, personal offices, or private homes. While the length of the survey was relatively short at approximately ten minutes, participants may have experienced technical issues that could have prevented them from completing the survey in a timely manner or even completing the survey at all. Since the sample consisted of professional psychologists, participants may have faced time constraints or concerns about anonymity regarding the setting where they filled out survey questions that may have influenced the level of honesty with which they responded.

While utilizing a web-based survey helps reach a diverse sample, the lack of environmental standardization may impact the quality and integrity of participant responses. Given the online nature of the survey, accessibility may also be limited, especially for participants with physical or sensory impairments.

Therapist clinical engagement was measured using a newly generated scale and is lacking information about concurrent and discriminate validity; therefore it is unknown how the CES correlates with other previously validated measures of therapeutic alliance. Likewise, there is no evidence to show that the CES is uncorrelated with instruments designed to measure theoretically different constructs. The average clinical engagement scores were quite high, and while this may have been due to actual participant strengths in both case conceptualization and alliance/collaboration tasks, it may also be related to scaling issues present within the Clinical Engagement Scale. High scores may also have been related to conditions of internet research or social desirability influence where participants were primed to be more sensitive to religious issues in counseling research. Another procedural concern is the frequency with which data was collected. Because this study was not a longitudinal study, clinical engagement scores reflect participants' self-reported level of engagement at a single point in time as opposed to multiple points throughout the counseling process. This methodological feature raises the questions about whether therapists' worldview impacts the counseling process in later stages where in the early stages the work of the therapist is about relating to the client on a human level. Participants may also have self-selected for this study

because of interest in religion and psychotherapy; therefore, results may have been influenced by participant bias thus limiting the generalizability of the findings.

REFERENCES

- Allport, G. W., & Ross, J. M. (1967). Personal religious orientation and prejudice. *Journal of Personality and Social Psychology*, 5(4), 432-443.
- American Association for Marriage and Family Therapy (2001). *AAMFT code of ethics*. Washington, DC: Author.
- American Counseling Association. (1996). *ACA code of ethics and standards of practice*. Alexandria, VA: Author.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Association.
- American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist*, 58(5), 377-402.
- Avants, S. K., Warburton, L. A., & Margolin, A. (2001). Spiritual and religious support in recovery from addiction among HIV-positive injection drug users. *Journal of Psychoactive Drugs*, 33(1), 39-45.
- Azhar, M., Varma, S., & Dharap, A. (1994). Religious psychotherapy in anxiety disorder patients. *Acta Psychiatrica Scandinavica*, 90(1), 1-3.
- Balkin, R. S., Schlosser, L. Z., & Levitt, D. H. (2009). Religious identity and cultural diversity: Exploring the relationships between religious identity, sexism, homophobia, and multicultural competence. *Journal of Counseling & Development*, 87(4), 420-427.

- Barbour, I. G. (1974). *Myths, models, and paradigms: A comparative study in science and religions*. NY: Harper & Row.
- Barnett, J. E., & Johnson, B. W. (2011). Integrating spirituality and religion into psychotherapy: Persistent dilemmas, ethical issues, and a proposed decision-making process. *Ethics and Behavior*, 2, 147-164.
- Baskin, T. W., & Enright, R. D. (2004). Intervention studies on forgiveness: A meta-analysis. *Journal of Counseling & Development*, 82(1), 79-90.
- Bay, P.S., Beckman, D., Trippi, J., Gunderman, R., Terry, C. (2008). The effect of pastoral care services on anxiety, depression, hope, religious coping, and religious problem solving styles: A randomized controlled study. *Journal of Religion and Health*, 47(1), 57-69.
- Beach, S. R. H., Hurt, T. R., Fincham, F. D., Franklin, K. J., McNair, L. M., & Stanley, S. M. (2011). Enhancing marital enrichment through spirituality: Efficacy data for prayer focused relationship enhancement. *Psychology of Religion and Spirituality*, 3(3), 201-216.
- Benjamin, P., & Looby, J. (1998). Defining the nature of spirituality in the context of Maslow's and Rogers' theories. *Counseling & Values*, 42(2), 92-101.
- Bergin, A. E. (1988). Three contributions of a spiritual perspective to counseling, psychotherapy, and behavior change. *Counseling and Values*, 33, 21-31.
- Bergin, A. E. (1991). Values and religious issues in psychotherapy and mental health. *American Psychologist*, 46(4), 394-403.

- Bergin, A. E., & Jensen, J. P. (1990). Religiosity of psychotherapists: A national survey. *Psychotherapy, 27*, 3 – 7.
- Bergin, A. E., Masters, K. S., & Richards, P. S. (1987). Religiousness and mental health reconsidered: A study of an intrinsically religious sample. *Journal of Counseling Psychology, 34*, 197-204.
- Bilgrave, D., & Deluty, R. (2002). Religious beliefs and political ideologies as predictors of psychotherapeutic orientations of clinical and counseling psychologists. *Psychotherapy: Theory, Research and Practice, 39*(3), 245-260.
- Bishop, D. R. (1992). Religious values as cross-cultural issues in counseling. *Counseling and Values, 36*, 179-191.
- Breitbart, W., Rosenfeld, B., Gibson, C., Pessin, H., Poppito, S., et al. (2010). Meaning-centered group psychotherapy for patients with advanced cancer: A pilot randomized controlled trial. *Psycho-Oncology, 19*(1), 21-28.
- Cashwell, C. S., Bentley, P. B., & Yarborough, J. P. (2007). The only way out is through: The peril of spiritual bypass. *Counseling and Values, 51*(2), 139.
- Cashwell, C. S., & Young, J. S. (Eds.). (2005). *Integrating spirituality and religion in counseling: A guide to competent practice*. American Counseling Association: Alexandria, VA.
- Coughlin, E. (1992). Social scientists again turn attention to religion's place in the world. *The Chronicle of Higher Education, 6*, A7, A8.

- Flaskerud, J. H. (1986). The effects of culture-compatible intervention on the utilization of mental health services by minority clients. *Community Mental Health Journal*, 22(2), 127-141.
- Fukuyama, M., & Sevig, T. (1997). Spiritual issues in counseling psychology: A new course. *Counselor Education and Supervision*, 36(3), 233-244. 148(1), 90-05.
- Gallup Organization. (2011). The Gallup Poll: Religion. Retrieved August 13, 2014, from <http://www.gallup.com/poll/159050/seven-americans-moderately-religious.aspx>
- Griffith, J., & Griffith, M. (2002). *Encountering the sacred in psychotherapy: How to talk with people about their spiritual lives*. New York: Guilford.
- Harris, J. I., Erbes, C. R., Engdahl, B. E., Thuras, P., Murray-Swank, N., et al. (2011). The effectiveness of a trauma focused spiritually integrated intervention for veterans exposed to trauma. *Journal of Clinical Psychology*, 67(4), 425-438.
- Hawkins, R. S., Tan, S., & Turk, A. A. (1999). Secular versus Christian inpatient cognitive-behavioral therapy programs: Impact on depression and spiritual well-being. *Journal of Psychology and Theology*, 27(4), 309-318.
- Heppner, P. P., Wampold, B. E., & Kivlighan, D. M. (2008). *Research design in counseling*. Belmont, CA: Thomson Brooks/Cole.
- Heise, R. G., & Steitz, J. A. (1991). Religious perfectionism versus spiritual growth. *Counseling and Values*, 36, 11-18.
- Hinterkopf, E. (1994). Integrating spiritual experience in counseling. *Counseling and Values*, 38, 165-175.

- Hunter, J. A. (2001). Self-esteem and in-group bias among members of a religious social category. *Journal of Social Psychology, 141*, 401–411.
- Ingersoll, R. E. (1998). Refining dimensions of spiritual wellness: A cross-traditional approach. *Counseling and Values, 42*(3), 156-156-165.
- Johnson, W. B. (1993). Outcome research and religious psychotherapies: Where are we and where are we going? *Journal of Psychology and Theology, 21*(4), 297-308.
- Johnson, W. B., Devries, R., Ridley, C., & Pettorini, D. (1994). The comparative efficacy of Christian and secular rational-emotive therapy with Christian clients. *Journal of Psychology and Theology, 22*(2), 130-140.
- Johnson, W. B. (1992). Brief Christian and non-Christian rational-emotive therapy. *Counseling & Values, 36*(3), 220.
- Johnson, W. B., Ridley, C. R., & Nielsen, S. L. (2000). Religiously sensitive rational emotive behavior therapy: Elegant solutions and ethical risks. *Professional Psychology: Research and Practice, 31*, 14–20.
- Jones, S. L. (1994). A constructive relationship for religion with science and the profession of psychology: Perhaps the boldest model yet. *American Psychologist, 49*, 184-199.
- Kahoe, R. D. (1977). Intrinsic religion and authoritarianism: A differentiated relationship. *Journal for the Scientific Study of Religion, 16*, 179-183.
- Katz, J. (1985). The sociopolitical nature of counseling. *The counseling Psychologist, 13*, 615-624.

- Kelly, E.W. (1995). *Spirituality and religion in counseling and psychotherapy: Diversity in theory and practice*. Alexandria, VA: American Counseling Association.
- Knox, S., Catlin, L., Casper, M., & Schlosser, L. Z. (2005). Addressing religion and spirituality in psychotherapy: Clients' perspectives. *Psychotherapy Research*, 15(3), 287-287-303.
- Koenig, H.G., McCullough, M.E., & Larson, D.B. (2001). *Handbook of religion and health*. New York. Oxford University Press.
- Kroll, J., & Sheehan, W. (1989). Religious beliefs and practices among 52 psychiatric inpatients in Minnesota. *The American Journal of Psychiatry*, 146, 67-72.
- Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training*, 38(4), 357-361.
- Larson, D. B., Lu, F. G. & Swyers, J. P. (Eds.). (1997). *Model curriculum for psychiatry residency training programs: Religion and spirituality in clinical practice*. (Revised Edition), Rockville, Maryland: The National Institute for Healthcare Research.
- Laythe, B., Finkel, D. G., Bringle, R. G., & Kirkpatrick, L. A. (2002). Religious fundamentalism as a predictor of prejudice: A two-component model. *Journal for the Scientific Study of Religion*, 41, 623–635.
- Lease, S. H., & Shulman, J. L. (2003). A preliminary investigation of the role of religion for family members of lesbian, gay male, or bisexual male and female individuals. *Counseling & Values*, 47, 195–209.

- Loring, M. & Powell, B. (1988). Gender, race, and DSM-III: A study of the objectivity of psychiatric diagnostic behavior. *Journal of Health and Social Behavior*, 29, 1-22.
- Mack, M. L. (1994). Understanding spirituality in counseling psychology: Considerations for research, training, and practice. *Counseling and Values*, 39, 15-31.
- Magaldi-Dopman, D., Park-Taylor, J., & Ponterotto, J. (2011). Psychotherapists' spiritual, religious, atheist or agnostic identity and their practice of psychotherapy: A grounded theory study. *Psychotherapy Research*, 21(3), 286-303.
- Margolin, A., Avants, S. K., & Arnold, R. (2005). Acupuncture and spirituality-focused group therapy for the treatment of HIV-positive drug users: A preliminary study. *Journal of Psychoactive Drugs*, 37(4), 385-385-390.
- May, R. (1982). The problem of evil: An open letter to Carl Rogers. *Journal of Humanistic Psychology*, 22(3), 10-19.
- McCullough & Worthington. (1994). Models of interpersonal forgiveness and their applications. *Counseling & Values*, 39(1), 2.
- McCullough, M. E. (1999). Research on religion-accommodative counseling: Review and meta-analysis. *Journal of Counseling Psychology*, 46(1), 92-92-98.
- Merriam-Webster Online Dictionary. (n.d). Retrieved August 9, 2014, from <http://www.merriam-webster.com/dictionary/humanitarian>.

- Miller, W. R., & Thoresen, C. E. (2003). Spirituality, religion, and health: An emerging research field. *American Psychologist*, 58(1), 24-35.
- Mohr, S., Borra, L., Betrisey, C., Pierre-Yves, B., Gillieron, C., & Huguelet, P. (2010). Delusions with religious content in patients with psychosis: How they interact with spiritual coping. *Psychiatry: Interpersonal and Biological Processes* 73(2), 158-172.
- Muijs, D. (2011). *Doing quantitative research in education with SPSS* (2nd ed.). Los Angeles, CA: Sage.
- Mutter, K. F., & Neves, C. M. (2010). A dialogical model for engaging spirituality in therapy. *Clinical Social Work Journal*, 38(2), 164-173.
- Pargament, K. I., Kennell, J., Hathaway, W., Grevengoed, N., Newman, J., & Jones, W. (1988). Religion and the problem-solving process: Three styles of coping. *Journal for the Scientific Study of Religion*, 27, 90-104.
- Pargament, K.I., & Saunders, S.M. (2007). Introduction to the special issue on spirituality and psychology. *Journal of Clinical Psychology*, 63(10), 903-907.
- Park, C. L., & Slattery, J. M. (2009). Including spirituality in case conceptualizations: A meaning-systems approach. In J. D. Aten, & M. M. Leach (Eds.), *Spirituality and the therapeutic process: A comprehensive resource from intake to termination*. (pp. 121-142) American Psychological Association.
- Pate, R. H., Jr., & Bondi, A. M. (1992). Religious beliefs and practice: An integral aspect of multicultural awareness. *Counselor Education and Supervision*, 32, 108-115.

- Peek, C. W., Lowe, G. D., & Williams, L. S. (1991). Gender and God's word: Another look at religious fundamentalism and sexism. *Social Forces*, 69, 1205–1221.
- Perkins, H. W. (1992). Student religiosity and social justice concerns in England and the United States: Are they still related? *Journal for the Scientific Study of Religion*, 31(3), 353-360.
- Pew Forum on Religion and Public Life. (2009). *U.S. religious landscape survey*. Retrieved from <http://religions.pewforum.org/affiliations>
- Pecheur, D., & Edwards, K. (1984). A comparison of secular and religious versions of cognitive therapy with depressed Christian college students. *Journal of Psychology and Theology*, 12(1), 45-54.
- Plante, T. G. (2009). *Spiritual practices in psychotherapy: Thirteen tools for enhancing psychological health*. American Psychological Association.
- Plante, T. G. (2007). Integrating spirituality and psychotherapy: Ethical issues and principles to consider. *Journal of Clinical Psychology*, 63(9), 891-902.
- Post, B. C., & Wade, N. G. (2009). Religion and spirituality in psychotherapy: A practice-friendly review of research. *Journal of Clinical Psychology*, 65(2), 131-146.
- Propst, L. R., Ostrom, R., Watkins, P., Dean, T., & Mashburn, D. (1992). Comparative efficacy of religious and nonreligious cognitive-behavioral therapy for the treatment of clinical depression in religious individuals. *Journal of Consulting and Clinical Psychology*, 60(1), 94-103.

- Razali, S. M., Hasanah, C. I., Aminah, K., & Subramaniam, M. (1998). Religious--sociocultural psychotherapy in patients with anxiety and depression. *Australian & New Zealand Journal of Psychiatry*, 32(6), 867-872.
- Richards, P. S., Berrett, M. E., & Hardman, R. K. (2006). Comparative efficacy of spirituality, cognitive, and emotional support group for treating eating disorder inpatients. *Eating Disorders*, 14(5), 401-415.
- Ridley, C. R., Ethington, L., & Heppner, P. (2008). Cultural confrontation: An advanced skill of cultural empathy. In P. Pedersen, J. Draguns, W. Lonner, & J. Trimble (Eds.). *Counseling Across Cultures* (6th ed., pp. 33-64). Thousand Oaks, CA: Sage.
- Ridley, C. R., Liddle, M. C., Hill, C. L., & Li, L. C. (2001). Ethical decision making in multicultural counseling. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of Multicultural Counseling* (2nd ed., pp. 165–188). Thousand Oaks, CA: Sage.
- Rosik, C. H., Griffith, L. K., & Cruz, Z. (2007). Homophobia and conservative religion: Toward a more nuanced understanding. *American Journal of Orthopsychiatry*, 77, 10–19.
- Rosmarin, D. H., Pargament, K. I., Pirutinsky, S., & Mahoney, A. (2010). A randomized controlled evaluation of a spiritually integrated treatment for subclinical anxiety in the Jewish community, delivered via the internet. *Journal of Anxiety Disorders*, 24(7), 799-808.

- Rye, M. S., & Pargament, K. I. (2002). Forgiveness and romantic relationships in college: Can it heal the wounded heart? *Journal of Clinical Psychology, 58*(4), 419-441.
- Rye, M. S., Pargament, K. I., Pan, W., Yingling, D. W., Shogren, K. A., & Ito, M. (2005). Can group interventions facilitate forgiveness of an ex-spouse? A randomized clinical trial. *Journal of Consulting and Clinical Psychology, 73*(5), 880-892.
- Shafranske, E. P., & Malony, N. H. (1985). *Religion, spiritual, and psychotherapy: A study of a California psychologist*. Paper presented at the meeting of the California State Psychological Association, San Francisco.
- Shafranske, E., & Malony, H. N. (1990). Clinical psychologists' religious and spiritual orientations and their practice of psychotherapy. *Psychotherapy: Theory, Research and Practice, 27*(1), 72-78.
- Smith, T. B., Bartz, J., & Richards, P. S. (2007). Outcomes of religious and spiritual adaptations to psychotherapy: A meta-analytic review. *Psychotherapy Research, 17*(6), 643-655.
- Sperry, L. (2005). Case conceptualization: A strategy for incorporating individual, couple and family dynamics in the treatment process. *The American Journal of Family Therapy, 33*(3), 353-364.
- Suyemoto, K., & MacDonald, M. (1996). The content and function of religious and spiritual beliefs. *Counseling and Values, 40*, 143-158.

- Swift, J.K., Callahan, J.L., & Vollmer, B.M. (2011). Preferences. In J.C. Norcross (Ed.), *Psychotherapy Relationships that Work: Evidence-Based Responsiveness* (2nd Edition, pp. 301-315). New York: Oxford University Press..
- Trimble, J. E., & Fisher, C. B. (Eds.). (2006a). *The handbook of ethical research with ethnocultural populations & communities*. Thousand Oaks, CA: Sage.
- Usher, C. H. (1989). Recognizing cultural bias in counseling theory and practice: The case of Rogers. *Journal of Multicultural Counseling and Development*, 17, 63-71.
- Worthington, E. L., Hook, J. N., Davis, D. E., & McDaniel, M. A. (2011). Religion and spirituality. *Journal of Clinical Psychology*, 67(2), 204-204-214.
- Worthington, E. L., Kurusu, T. A., McCullough, M. E., & Sandage, S. J. (1996). Empirical research on religion and psychotherapeutic processes and outcomes: A 10-year review and research prospectus. *Psychological Bulletin*, 119(3), 448-448-487.
- Worthington, E. L., Davis, D. E., Hook, J. N., Miller, A. J., Gartner, A. L., et al. (2011). *Promoting forgiveness as a religious or spiritual intervention*. In: J. D. Aten, M. R. McMinn & E. L. Worthington, Jr. (Eds.). *Spiritually oriented interventions for counseling and psychotherapy*. Washington, DC: American Psychological Association, pp. 169 – 195.
- Worthington, E. L., Jr., Dupont, P. D., Berry, J. T., & Duncan, L. A. (1988). Christian therapists' and clients' perceptions of religious psychotherapy in private and agency settings. *Journal of Psychology and Theology*, 16, 282–293.

Worthington, E. L., Jr., Wade, N. G., Hight, T. L., Ripley, J. S., McCullough, M. E., et al. (2012). The Religious Commitment Inventory-10 (RCI-10). Measurement Instrument Database for the Social Science. Retrieved from www.midss.ie

Worthington, E. L., Jr., Wade, N. G., Hight, T. L., Ripley, J. S., McCullough, M. E., et al. (2003). The Religious Commitment Inventory-10: Development, refinement, and validation of a brief scale for research and counseling. *Journal of Counseling Psychology, 50*(1), 84-96

Yarhouse, M. A., & Fisher, W. E. (2002). Levels of training to address religion in clinical practice. *Psychotherapy, 39*(2), 171-176.

APPENDIX A

CLINICAL CASE VIGNETTE

Religious Problem – Unhealthy Ideation

I am a 32 year old woman, and I've never been to counseling before. I grew up in Oklahoma with my mother and father, my younger sister, and older brother. My brother died from cancer when I was nine and my family hasn't talked much about his death. We don't talk about his death because he's in heaven. My parents and I have an okay relationship, but I don't feel close to them. They don't live far from me and we see each other at church on Sundays, but whenever we are together I get so mad and frustrated with them it isn't worth trying to talk to them. I've been married for about 7 years, and we don't have any children. I guess I haven't been really happy for a few years now, and nothing I do seems to help. My husband seems to be just as unhappy with me but he hasn't done anything to change and I'm just not willing to put in any effort if he's not willing to change first. Sometimes I think I'd be a happier person if I could just leave and replace him with a better husband. My husband and I fight all the time, but we can't get a divorce because my religion says divorce is a sin. I pray to God that he would fix our marriage, but he hasn't done it yet. I've been reading my bible and praying all the time, but still God hasn't fixed my marriage. I used to love being around people and always had a lot of close friends, but now it seems like no one wants to be around me anymore. So, I usually just spend a lot of time at home. I just want to come to counseling so that you can fix my marriage. Some days I feel completely worthless, and other days I'm so angry with everyone. But every time I recognize I'm angry, I tell myself to stop being angry because that's not what good Christians do. I feel like my emotions are all over the place. Sometimes I'm so jumpy I can't stand to sit still and other times it's like I don't have any feelings at all. I never can figure out why I feel these ways – they just seem to come out of nowhere.

Religious Problem – Healthy Ideation

I am a 32 year old woman, and I've never been to counseling before. I grew up in Oklahoma with my mother and father, my younger sister, and older brother. My brother died from cancer when I was nine and my family hasn't talked much about his death. We

don't talk about his death because he's in heaven. My parents and I have an okay relationship, but I don't feel close to them. They don't live far from me and we see each other at church on Sundays, but whenever we are together I get so mad and frustrated with them it isn't worth trying to talk to them. I've been married for about 7 years, and we don't have any children. I guess I haven't been really happy for a few years now, and nothing I do seems to help. My husband seems to be just as unhappy with me as I am with myself. Sometimes I think I'd be a happier person if I could just leave and start again on my own. My husband and I fight all the time, but we have agreed to stay married because it's against my religion to divorce so we have decided to come to counseling so we can gain tools to improve our marriage. I pray to God that he would help me understand why I've been so unhappy. I've been reading my bible and praying all the time to help me get through these difficult times. I used to love being around people and always had a lot of close friends, but now it seems like people don't want me around anymore. So, I usually just spend a lot of time at home. I'd just like to learn ways to handle my emotions and cope with disagreement in my marriage that fit with my religious beliefs. Some days I feel completely worthless, and other days I'm so angry with everyone. Every time I recognize I'm angry I just don't know what to do to calm down. I feel like my emotions are all over the place. Sometimes I'm so jumpy I can't stand to sit still and other times it's like I don't have any feelings at all. I never can figure out why I feel these ways – they just seem to come out of nowhere.

Non-Religious Problem – Unhealthy Ideation

I am a 32 year old woman, and I've never been to counseling before. I grew up in Oklahoma with my mother and father, my younger sister, and older brother. My brother died from cancer when I was nine and my family hasn't talked much about his death. We don't talk about his death. My parents and I have an okay relationship, but I don't feel close to them. They don't live far from me and we see each other on Sundays, but whenever we are together I get so mad and frustrated with them it isn't worth trying to talk to them. I've been married for about 7 years, and we don't have any children. I guess I haven't been really happy for a few years now, and nothing I do seems to help. My husband seems to be just as unhappy with me but he hasn't done anything to change and I'm just not willing to put in any effort if he's not willing to change first. Sometimes I think I'd be a happier person if I could just leave and replace him with a better husband. My husband and I fight all the time, and he blames me and I blame him for the problems in our marriage. I used to love being around people and always had a lot of close friends, but now it seems like no one wants to be around me anymore. So, I usually

just spend a lot of time at home. I just want to come to counseling so that you can give me advice on how to help my husband change so we can have a better marriage. Some days I feel completely worthless, and other days I'm so angry with everyone. Every time I recognize I feel like I'm angry I just don't know what to do to calm down. I feel like my emotions are all over the place. Sometimes I'm so jumpy I can't stand to sit still and other times it's like I don't have any feelings at all. I never can figure out why I feel these ways – they just seem to come out of nowhere.

Non-Religious Problem – Healthy Ideation

I am a 32 year old woman, and I've never been to counseling before. I grew up in Oklahoma with my mother and father, my younger sister, and older brother. My brother died from cancer when I was nine and my family hasn't talked much about his death. We don't talk about his death. My parents and I have an okay relationship, but I don't feel close to them. They don't live far from me and we see each other on Sundays, but whenever we are together I get so mad and frustrated with them it isn't worth trying to talk to them. I've been married for about 7 years, and we don't have any children. I guess I haven't been really happy for a few years now, and nothing I do seems to help. My husband seems to be just as unhappy with me as I am with myself. Sometimes I think I'd be a happier person if I could just leave and start again on my own. My husband and I fight all the time, but we have agreed to go to counseling so we can gain tools to improve our marriage. I used to love being around people and always had a lot of close friends, but now it seems like people don't want me around anymore. So, I usually just spend a lot of time at home. I'd just like to learn how to handle my emotions and cope with disagreement in my marriage. Some days I feel completely worthless, and other days I'm so angry with everyone. Every time I recognize I'm angry I just don't know what to do to calm down. I feel like my emotions are all over the place. Sometimes I'm so jumpy I can't stand to sit still and other times it's like I don't have any feelings at all. I never can figure out why I feel these ways – they just seem to come out of nowhere.

APPENDIX B
VIGNETTE SCRIPTS

Vignette #1

Counselor: Tell me a little bit about yourself

Client: I am a 32 year old woman, and I've never been to counseling before. I grew up in Oklahoma with my mother and father, my younger sister, and older brother. My brother died from cancer when I was nine and my family hasn't talked much about his death. We don't talk about his death because he's in heaven.

Counselor: How do you get along with your family?

Client: My parents and I have an okay relationship, but I don't feel close to them. They don't live far from me and we see each other at church on Sundays, but whenever we are together I get so mad and frustrated with them it isn't worth trying to talk to them.

Counselor: (Feel free to add your own touch here to transition) So, tell me what brings you into therapy at this time?

Client: I've been married for about 7 years, and we don't have any children. I guess I haven't been really happy for a few years now, and nothing I do seems to help. My husband seems to be just as unhappy with me but he hasn't done anything to change and I'm just not willing to put in any effort if he's not willing to change first. Sometimes I think I'd be a happier person if I could just leave and replace him with a better husband. My husband and I fight all the time, but we can't get a divorce because my religion says divorce is a sin. I pray to God that he would fix our marriage, but he hasn't done it yet. I've been reading my bible and praying all the time, but still God hasn't fixed my

marriage. I used to love being around people and always had a lot of close friends, but now it seems like no one wants to be around me anymore. So, I usually just spend a lot of time at home.

Counselor: How do you think counseling can help you?

Client: I just want to come to counseling so that you can fix my marriage. Some days I feel completely worthless, and other days I'm so angry with everyone. But every time I recognize I'm angry, I tell myself to stop being angry because that's not what good Christians do. I feel like my emotions are all over the place. Sometimes I'm so jumpy I can't stand to sit still and other times it's like I don't have any feelings at all. I never can figure out why I feel these ways – they just seem to come out of nowhere.

Counselor: [minimal encouragers]

Vignette #2

Counselor: Tell me a little bit about yourself

Client: I am a 32 year old woman, and I've never been to counseling before. I grew up in Oklahoma with my mother and father, my younger sister, and older brother. My brother died from cancer when I was nine and my family hasn't talked much about his death. We don't talk about his death because he's in heaven.

Counselor: How do you get along with your family?

Client: My parents and I have an okay relationship, but I don't feel close to them. They don't live far from me and we see each other at church on Sundays, but whenever we are together I get so mad and frustrated with them it isn't worth trying to talk to them.

Counselor: So, tell me what brings you into therapy at this time?

Client: I've been married for about 7 years, and we don't have any children. I guess I haven't been really happy for a few years now, and nothing I do seems to help. My husband seems to be just as unhappy with me as I am with myself. Sometimes I think I'd be a happier person if I could just leave and start again on my own. My husband and I fight all the time, but we have agreed to stay married because it's against my religion to divorce so we have decided to come to counseling so we can gain tools to improve our marriage. I pray to God that he would help me understand why I've been so unhappy. I've been reading my bible and praying all the time to help me get through these difficult times. I used to love being around people and always had a lot of close friends, but now it seems like people don't want me around anymore. So, I usually just spend a lot of time at home.

Counselor: *How do you think counseling can help you?*

Client: I'd just like to learn ways to handle my emotions and cope with disagreement in my marriage that fit with my religious beliefs. Some days I feel completely worthless, and other days I'm so angry with everyone. Every time I recognize I'm angry I just don't know what to do to calm down. I feel like my emotions are all over the place. Sometimes I'm so jumpy I can't stand to sit still and other times it's like I don't have any feelings at all. I never can figure out why I feel these ways – they just seem to come out of nowhere.

Counselor: *[minimal encouragers]*

Vignette #3

Counselor: *Tell me a little bit about yourself*

Client: I am a 32 year old woman, and I've never been to counseling before. I grew up in Oklahoma with my mother and father, my younger sister, and older brother. My

brother died from cancer when I was nine and my family doesn't talk much about his death.

Counselor: How do you get along with your family?

Client: My parents and I have an okay relationship, but I don't feel close to them. They don't live far from me and we see each other on Sundays, but whenever we are together I get so mad and frustrated with them it isn't worth trying to talk to them.

Counselor: So, tell me what brings you into therapy at this time?

Client: I've been married for about 7 years, and we don't have any children. I guess I haven't been really happy for a few years now, and nothing I do seems to help. My husband seems to be just as unhappy with me but he hasn't done anything to change and I'm just not willing to put in any effort if he's not willing to change first. Sometimes I think I'd be a happier person if I could just leave and replace him with a better husband. My husband and I fight all the time, and he blames me and I blame him for the problems in our marriage. I used to love being around people and always had a lot of close friends, but now it seems like no one wants to be around me anymore. So, I usually just spend a lot of time at home.

Counselor: How do you think counseling can help you?

Client: I just want to come to counseling so that you can give me advice on how to help my husband change so we can have a better marriage. Some days I feel completely worthless, and other days I'm so angry with everyone. Every time I recognize I feel like I'm angry I just don't know what to do to calm down. I feel like my emotions are all over the place. Sometimes I'm so jumpy I can't stand to sit still and other times it's like I

don't have any feelings at all. I never can figure out why I feel these ways – they just seem to come out of nowhere.

Counselor: [minimal encouragers]

Vignette #4

Counselor: Tell me a little bit about yourself

Client: I am a 32 year old woman, and I've never been to counseling before. I grew up in Oklahoma with my mother and father, my younger sister, and older brother. My brother died from cancer when I was nine and my family doesn't talk about his death.

Counselor: How do you get along with your family?

Client: My parents and I have an okay relationship, but I don't feel close to them. They don't live far from me and we see each other on Sundays, but whenever we are together I get so mad and frustrated with them it isn't worth trying to talk to them

Counselor: So, tell me what brings you into therapy at this time?

Client: I've been married for about 7 years, and we don't have any children. I guess I haven't been really happy for a few years now, and nothing I do seems to help. My husband seems to be just as unhappy with me as I am with myself. Sometimes I think I'd be a happier person if I could just leave and start again on my own. My husband and I fight all the time, but we have agreed to go to counseling so we can gain tools to improve our marriage. I used to love being around people and always had a lot of close friends, but now it seems like people don't want me around anymore. So, I usually just spend a lot of time at home.

Counselor: How do you think counseling can help you?

Client: I'd just like to learn how to handle my emotions and cope with disagreement in my marriage. Some days I feel completely worthless, and other days I'm so angry with everyone. Every time I recognize I'm angry I just don't know what to do to calm down. I feel like my emotions are all over the place. Sometimes I'm so jumpy I can't stand to sit still and other times it's like I don't have any feelings at all. I never can figure out why I feel these ways – they just seem to come out of nowhere.

Counselor: *[minimal encouragers]*

APPENDIX C
DEMOGRAPHIC QUESTIONNAIRE

Age: _____
Gender: Male Female Transgendered Other _____
Race/Ethnicity:
African American
Asian American
Latina/Latino
Native American
White
Other _____
State of Residence: _____
Your primary field of study:
Counseling Psychology
Clinical Psychology
School Psychology
Other _____
Your highest degree received: Ph.D. Psy.D. Ed.D.
Number of years practicing psychology: _____
Do you identify yourself as:
1) Religious but not spiritual 2) Religious and spiritual 3) A nonreligious person
If you chose #1 or #2, what religious practice do you follow if any?

IRB NUMBER: IRB2012-0773 IRB APPROVAL DATE: 04/16/2013 IRB
EXPIRATION DATE: 04/15/2014

APPENDIX D

RCI-10

RELIGIOUS COMMITMENT INVENTORY-10

Instructions:

Read each of the following statements and using the scale below, SELECT the response that best describes how true each statement is for you.

Not at all true of me	Somewhat true of me	Moderately true of me	Mostly true of me	Totally true of me
1	2	3	4	5

1. I often read books and magazines about my faith.

1 2 3 4 5

2. I make financial contributions to my religious organization.

1 2 3 4 5

3. I spend time trying to grow in understanding of my faith.

1 2 3 4 5

4. Religion is especially important to me because it answers many questions about the meaning of life.

1 2 3 4 5

5. My religious beliefs lie behind my whole approach to life.

1 2 3 4 5

6. I enjoy spending time with others of my religious affiliation.

1 2 3 4 5

7. Religious beliefs influence all my dealings in life.

1 2 3 4 5

8. It is important to me to spend periods of time in private religious thought and reflection.

1 2 3 4 5

9. I enjoy working in the activities of my religious affiliation.

1 2 3 4 5

10. I keep well informed about my local religious group and have some influence in its decisions.

1 2 3 4 5

Worthington, E. L., Jr., Wade, N. G., Hight, T. L., Ripley, J. S., McCullough, M. E., Berry, J. W., Schmitt, M. M., Berry, J. T., Bursley, K. H., & Conner, L. (2012). The Religious Commitment Inventory-10 (RCI-10). Measurement Instrument Database for the Social Science. Retrieved from www.midss.ie

APPENDIX E

PERMISSION TO USE RCI-10

Research project question

Courtney Nelson <courtney.d.francis@gmail.com>
To: Everett L Worthington <eworth@vcu.edu>

Tue, Jan 28, 2014 at 3:44

Dr. Worthington,

I appreciate your feedback. I would like to use the RCI-10 for my dissertation study and would like your permission to do so. Will an email suffice?

Sincerely,
Courtney Nelson
[Quoted text hidden]

--

Courtney

Courtney Francis
Doctoral Student
Counseling Psychology
Texas A&M University

Everett L Worthington <eworth@vcu.edu>
To: Courtney Nelson <courtney.d.francis@gmail.com>

Tue, Jan 28, 2014 at 5:31 PM

Yes. You have my permission.

Ev
[Quoted text hidden]

--

Everett L. Worthington, Jr.
Department of Psychology
(mail) Box 842018
Richmond, VA 23284-2018
(location) 800 W Franklin St (Room 101)
Phone: 804-828-1150

APPENDIX F

CLINICAL ENGAGEMENT SCALE

Instructions:

Read each of the following statements and using the scale below, SELECT the response that best describes how true each statement is for you if you were the therapist working with the client in the video.

To what extent:

1. Can you accurately conceptualize the client's problem presentation?
(not at all) 1 2 3 4 5 6 7 (very much)
2. Can you establish interventions appropriate to the client's problem presentation?
(not at all) 1 2 3 4 5 6 7 (very much)
3. Can you establish a therapeutic alliance with the client?
(definitely not) 1 2 3 4 5 6 7 (completely)
4. Can you connect the consequences of the inconsistencies in the client's feelings, beliefs, and attitudes with the client's dysfunctional behavior?
(not at all) 1 2 3 4 5 6 7 (very much)
5. Are you motivated to help the client change?
(not at all) 1 2 3 4 5 6 7 (very much)
6. Can you empathize with the client?
(definitely not) 1 2 3 4 5 6 7 (completely)

7. Can you be impartial in your conceptualization of the client's problem presentation?
- (not at all) 1 2 3 4 5 6 7 (very much)
8. Can you help the client achieve positive therapeutic outcomes?
- (not at all) 1 2 3 4 5 6 7 (very much)
9. Can you comprehensively conceptualize the client's problem presentation?
- (not at all) 1 2 3 4 5 6 7 (very much)
10. Can you clarify inconsistencies in the client's feelings, beliefs, attitudes, and behaviors?
- (not at all) 1 2 3 4 5 6 7 (very much)
11. Can you challenge the client to become consistent in their feelings, beliefs, and attitudes?
- (not at all) 1 2 3 4 5 6 7 (very much)
12. Can you collaborate with the client to set suitable treatment goals?
- (not at all) 1 2 3 4 5 6 7 (very much)

IRB NUMBER: IRB2012-0773D IRB APPROVAL DATE: 04/10/2014 IRB

EXPIRATION DATE: 04/01/2015

APPENDIX G
INFORMED CONSENT AGREEMENT

TITLE: Religious and Non-religious Therapists' Clinical Engagement as a Function of Selected Therapist and Client Variables.

INVESTIGATOR: Courtney Nelson, BA and Charles Ridley, PhD, Department of Counseling Psychology

PURPOSE OF THE RESEARCH: You are invited to participate in the dissertation project entitled, exploring the effectiveness of therapists working with clients presenting with both religious and non-religious presenting problems, which is being conducted at Texas A&M University under the direction of Courtney Nelson and Charles Ridley, PhD.

PROCEDURES TO BE FOLLOWED DURING THE RESEARCH: This research will be conducted online. It will take you about 10 minutes to complete the study. During the study you will first be asked answer questions regarding your demographic, then fill out a survey regarding your religious attitudes, thoughts, and beliefs. Next you will asked to watch a brief intake session and imagine that you are the clinician working with client in the video. Finally, you will also be asked to complete a final survey about the client from the video.

CONFIDENTIALITY: You have a right to privacy and participation in this study is anonymous and any identifiable information gathered such as email address will be kept separately from your survey answers. The results of this study may be published in a scientific journal and be presented at professional meetings however no identifying information will be presented.

People who have access to your information include the Principal Investigator and research study personnel. Representatives of regulatory agencies such as the Office of Human Research Protections (OHRP) and entities such as the Texas A&M University Human Subjects Protection Program may access your records to make sure the study is being run correctly and that information is collected properly. Information about you and related to this study will be kept anonymous to the extent permitted or required by law.

RISKS: There is minimal risk to involvement in this study – some individuals may find participating in this study to be uncomfortable and may stop at any time.

BENEFITS OF THE RESEARCH: There are no direct benefits to participation in this study.

COMPENSATION: In appreciation of your participation, two participants will be randomly selected and compensated with one \$50 Amazon gift card sent via email. You

have the option to decline this, in which case no money will be compensated for your participation.

QUESTIONS ABOUT THE RESEARCH: If you have questions regarding this research project or your participation, you may call Courtney Nelson at (817)597-6571 or Charles Ridley, PhD at (979)862-6584. For questions about your rights as a research participant; or if you have questions, complaints, or concerns about the research, you may call the Texas A&M University Human Subjects Protection Program office at (979) 458-4067 or irb@tamu.edu.

PARTICIPANT RIGHTS AND RESEARCH WITHDRAWAL: Participation in this study is voluntary and you have the right to leave a study at any time without penalty. You may refuse to do any procedures you do not feel comfortable with, or answer any questions that you do not wish to answer. If you withdraw from the study, you may request that your research information not be used by contacting the Principal Investigator listed above and below.

SIGNATURE AND ACKNOWLEDGMENT: By checking the box “agree to participate” you are electronically signing this form and agreeing to participate in this research study. You are also indicating that you have read the above information and agree to participate in the study until you decide otherwise. By checking the box “agree to participate” you also acknowledge that you have received a copy of this agreement and a copy of the Participant’s Bill of Rights.

APPENDIX H

RECRUITMENT EMAILS

Initial Recruitment Email

Dear Prospective Participant:

My name is Courtney Nelson and I am a graduate student in the Department of Counseling Psychology at Texas A&M University. I am currently working on my doctoral dissertation, chaired by Dr. Charles Ridley, and would like to ask you to participate in my research study exploring the effectiveness of therapists working with clients presenting with both religious and non-religious presenting problems.

Your participation in this study is completely voluntary and you may withdraw at any time without penalty. If you choose to participate, it will take approximately 10 minutes of your time. All of your responses will be kept anonymous and will only be available to the researchers in this study. Upon completion of the survey, you will have the option of submitting your email address to the researcher to enter into a drawing for a chance to win one of two gift certificates for \$50 from Amazon.

If you know other psychologists who may be interested in participating in this study, please feel free to pass along this email advertisement or post the link to a social networking website.

If you would like to participate in this study, please visit the following website:

https://tamu.qualtrics.com/SE/?SID=SV_0kt95DBrYKlg3Hv

To encourage participation, you may be contacted up to 2 more times; however, your email address will not be used for any other purposes. If you choose to enter into the drawing, you will be contacted if your name is randomly chosen.

If you have any questions or concerns about this study, please feel free to contact me by email at cfranci@tamu.edu or by phone at (817) 597-6571. You may also contact Dr. Ridley by email at cr Ridley@tamu.edu.

Thank you for taking the time to assist me in this research.
Courtney Nelson

This study has been reviewed and approved by the TAMU Human Subjects Protection Program. Questions concerning your rights as a participant in this research may be addressed to Texas A&M University Human Subjects Protection Program, TAMU, College Station, TX 77843. Phone (979) 458- 4067. E-mail irb@tamu.edu.

Follow-up Recruitment Email

Dear Prospective Participant:

This is a follow-up email for the research study about the effectiveness of therapists working with clients presenting with both religious and non-religious presenting problems. My name is Courtney Nelson and I am a graduate student in the Department of Counseling Psychology at Texas A&M University. Your e-mail address was obtained through a listserv or through the APA member directory. I am currently working on my doctoral dissertation, chaired by Dr. Charles Ridley. If you have already participated in this study, we thank you. However, if you have not, this is a friendly reminder.

Your participation in this study is completely voluntary and you may withdraw at any time without penalty. If you choose to participate, it will take approximately **10 minutes** of your time. All of your responses will be kept anonymous and will only be available to the researchers in this study. Upon completion of the survey, you will have the option of submitting your email address to the researcher to enter into a drawing for a chance to win one of two gift certificates for \$50 from Amazon.

If you know other psychologists who may be interested in participating in this study, please feel free to pass along this email advertisement or post the link to a social networking website.

If you would like to participate in this study, please visit the following website:

https://tamu.qualtrics.com/SE/?SID=SV_0kt95DBrYKlg3Hv

To encourage participation, you may be contacted up to 1 more time; however, your email address will not be used for any other purposes. If you choose to enter into the drawing, you will be contacted if your name is randomly chosen.

If you have any questions or concerns about this study, please feel free to contact me by email at cfranci@tamu.edu or by phone at (817) 597-6571. You may also contact Dr. Ridley by email at cridley@tamu.edu.

Thank you for taking the time to assist me in this research.

Courtney Nelson

Final Reminder Recruitment Email

Dear Prospective Participant:

This is a **final reminder** to participate in the research study about the effectiveness of therapists working with clients presenting with both religious and non-religious presenting problems. My name is Courtney Nelson and I am a graduate student in the Department of Counseling Psychology at Texas A&M University. Your e-mail address was obtained through a listserv or through the APA member directory. I am currently working on my doctoral dissertation, chaired by Dr. Charles Ridley. If you have already participated in this study, we thank you. However, if you have not, this is a friendly reminder.

Your participation in this study is completely voluntary and you may withdraw at any time without penalty. If you choose to participate, it will take approximately 10 minutes of your time. All of your responses will be kept anonymous and will only be available to the researchers in this study. Upon completion of the survey, you will have the option of submitting your email address to the researcher to enter into a drawing for a chance to win one of two gift certificates for \$50 from Amazon.

If you know other psychologists who may be interested in participating in this study, please feel free to pass along this email advertisement or post the link to a social networking website.

If you would like to participate in this study, please visit the following website :

https://tamu.qualtrics.com/SE/?SID=SV_0kt95DBrYKlg3Hv

If you have any questions or concerns about this study, please feel free to contact me by email at cfranci@tamu.edu or by phone at (817) 597-6571. You may also contact Dr. Ridley by email at cridley@tamu.edu.

Thank you for taking the time to assist me in this research.

Courtney Nelson